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No. 86-1764

In the Supreme Court of the United States

OCTOBER TERM, 1987

BETHESDA HOSPITAL ASSOCIATION, ET AL.,
PETITIONERS,

v.

OTIS R. BOWEN, M.D., SECRETARY
OF HEALTH AND HUMAN SERVICES,
RESPONDENT.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SIXTH CIRCUIT

JOINT APPENDIX

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PETITION FOR CERTIORARI FILED MAY 2, 1987
CERTIORARI GRANTED OCTOBER 5, 1987

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UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF OHIO

Civil Action No.
C-1-83-0622

BETHESDA HOSPITAL, ET AL., PLAINTIFFS,

v.

MARGARET M. HECKLER,
SECRETARY OF HEALTH AND HUMAN SERVICES
ROOM 615-F HUMPHREY BUILDING
200 INDEPENDENCE AVENUE, S.W.
WASHINGTON, D.C. 20201, DEFENDANT.

(Filed November 4, 1983)

AMENDED COMPLAINT FOR DECLARATORY AND INJUNCTIVE RELIEF AND SUMS DUE UNDER THE MEDICARE STATUTE

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(Filed November 4, 1983)

AMENDED COMPLAINT FOR DECLARATORY AND INJUNCTIVE RELIEF AND SUMS DUE UNDER THE MEDICARE STATUTE

This is an action for declaratory and injunctive relief to determine questions of actual controversy between the parties, and requests a determination of the rights granted plaintiffs and the duties imposed upon defendant by Title XVIII of the Social Security Act, as amended, Health Insurance for the Aged and Disabled, commonly known as the Medicare program. Specifically, this action challenges the procedural and substantive validity of a regulatory amendment issued by the Secretary of Health, Education, and Welfare on June 1, 1979. The regulation effected a fundamental change in the Medicare method of reimbursement for malpractice insurance costs incurred by hospitals providing services to Medicare patients. The malpractice apportionment regulation, 42 C.F.R. § 405.452(b)(1)(ii), is a radical departure from long-

standing Medicare reimbursement principles and is inconsistent therewith; it was promulgated in violation of the Administrative Procedure Act, 5 U.S.C. § 553; and it is arbitrary, capricious, and in conflict with the Medicare statute. The result of the regulation is the reduction of reimbursement to plaintiff hospitals to less than the statutory standard of the "reasonable cost" of providing hospital services to Medicare patients; in addition, the regulation results in a prohibited shifting of costs of providing such services from the Medicare program to non-Medicare patients.

PARTIES

1. Plaintiffs (hereinafter "providers" or "hospitals") are licensed as acute general hospitals by the State of Ohio and are certified as "providers" of such services under Part A of the Medicare program. 42 U.S.C. § 1395x(u).

2. Defendant, Margaret M. Heckler (hereinafter "Secretary"), is the Secretary of Health and Human Services, and as such is responsible for the administration of the Department of Health and Human Services (HHS),* including the Medicare program. The Health Care Financing Administration (HCFA) is the operating component of HHS charged with administration of the Medicare program.

JURISDICTION AND VENUE

3. This action arises under Title XVIII of the Social Security Act, 42 U.S.C. §§ 1395-1395xx (1974 and Supp.

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* The Department of Health and Human Services succeeded the Department of Health, Education, and Welfare (HEW) on May 4, 1980, pursuant to section 509(a) of the Department of Education Organization Act, Pub. L. 96-88, 93 Stat. 668. 42 F.R. 29642.

1982); the Administrative Procedure Act, 5 U.S.C. § 553; and the Declaratory Judgment Act, 28 U.S.C. § 2201.

4. Jurisdiction is grounded in 42 U.S.C. § 1395oo(f) and, with respect to Count I, in 28 U.S.C. § 1331.

5. Venue lies in this judicial district pursuant to 42 U.S.C. § 1395oo(f)(1).

THE MEDICARE PROGRAM

6. Title XVIII of the Social Security Act establishes a program of health insurance for the aged and disabled, commonly known as "Medicare." 42 U.S.C. §§ 1395-1395xx.

7. To participate in the Medicare program, a hospital must file a "provider agreement" with the Secretary of Health and Human Services pursuant to 42 U.S.C. § 1395cc, under which it agrees not to charge any Medicare patient for services covered by the Medicare program, in return for reimbursement by the program of the "reasonable cost" of such services. 42 U.S.C. § 1395f(b)(1)(A).

8. The regulations implementing the Medicare statute must ensure reimbursement of providers on the basis of the "reasonable cost" of such services. 42 U.S.C. §§ 1395x(v)(1)(A). "Reasonable cost" is defined as the "cost actually incurred, excluding therefrom any part of the incurred costs found to be unnecessary in the efficient delivery of needed health services. . . ." *Id.*

9. In promulgating regulations defining "reasonable cost," the Secretary is specifically directed by 42 U.S.C. § 1395x(v)(1)(A) to take into account both the direct and indirect costs of providers of services; to consider, among other things, the principles generally applied by national organizations or established prepayment organizations in making third-party payments for medical care; and to ensure that "the necessary costs of efficiently delivering

covered services to individuals covered by the [Medicare] program . . . will not be borne by individuals not so covered. . . ."

10. The Secretary has issued regulations to determine "reasonable cost" of services to Medicare beneficiaries. 42 C.F.R. Part 405, Subpart D, §§ 405.401-405.488.

FACTS RELATING TO PLAINTIFFS

11. During the cost years here at issue, each plaintiff had a provider agreement with the Secretary for the provision of Medicare services. The plaintiffs are appealing intermediary settlements for cost years ending in 1980 and 1981. (The cost years at issue and amounts in controversy are listed in the schedules attached to the Provider Reimbursement Review Board notices appended to this Complaint.)

12. The providers obtain malpractice insurance coverage through payment of premiums or contributions to self-insurance funds. The allowability of their malpractice insurance costs is not in dispute.

13. For the cost years here at issue, certain of the providers were legally obligated under the terms of borrowing indentures to obtain and maintain malpractice insurance coverage.

14. Prior to the challenged regulation, each plaintiff was reimbursed for its malpractice premium costs on the basis of Medicare utilization of services. The Medicare utilization rates for plaintiffs range from 19% to 50% for the cost years at issue.

15. All but two plaintiffs claimed reimbursement for malpractice insurance costs on that basis for the cost years at issue, despite the Medicare regulation and program instructions to the contrary. The providers' fiscal intermediary determined reimbursement for the providers' malpractice insurance costs on the basis of the challenged malpractice apportionment regulation, rather than those

claimed on the basis of utilization. The costs so claimed were disallowed by the intermediaries, and those cost years were accepted by the Board as properly before it.

16. Under the intermediary's Medicare reimbursement policies, however, inclusion of "nonallowable" costs in the cost report may be considered an act of fraud or program abuse. Similarly, if a provider claims as reimbursable an item which had been disallowed in a prior year, the provider may be subject to prosecution for Medicare fraud and abuse. Accordingly, following intermediary and Medicare program instructions, plaintiffs Bethesda Hospital and Deaconess Hospital for their cost years 1980 claimed only those malpractice insurance costs permitted by the new regulation, and filed an appeal with the Board after they received their Notices of Program Reimbursement. The Board refused to exercise jurisdiction over those cost years.

17. Those providers with no paid malpractice claims for the five-year period established by the regulation were reimbursed on the basis of a "national ratio" (5.1%) established by the regulation for the cost years at issue.

18. On March 24, 1982, plaintiffs requested a group hearing before the Provider Reimbursement Review Board pursuant to 42 U.S.C. § 1395oo(a) appealing the malpractice insurance costs disallowed in their Notices of Program Reimbursement.

19. On January 10, 1983, plaintiffs filed with the PRRB their brief and supporting materials. (The brief and supporting materials were reproduced in the Attachment to the original Complaint.)

20. The sole issue raised by plaintiffs' appeal of these cost years is the legality of the malpractice regulation.

21. Upon being informed that the PRRB would grant no hearings in any case which challenged the validity of the malpractice regulation, the group requested permission to

institute a civil action in federal district court pursuant to 42 U.S.C. § 1395oo(f)(1).

22. On February 18, 1983, the PRRB issued a notice that it lacks the authority to determine the validity of the malpractice regulation, and granted the group permission to proceed to federal court on an expedited basis. (Appendix A to original Complaint.) With respect to cost years for Bethesda Hospital and Deaconess Hospital, the PRRB concluded that it had no jurisdiction over their appeals because the providers did not claim reimbursement for their malpractice insurance costs based on Medicare utilization, despite the fact that they had simply followed the Secretary's regulations and instructions in filing their cost reports. (Appendix B to original Complaint.)

THE CHALLENGED REGULATION

23. Medicare regulations require providers to account for their expenses in various "cost centers." 42 C.F.R. § 405.453.

24. From its inception, the Medicare program has reimbursed both the direct and the indirect costs of each cost center on the basis of Medicare patients' actual use of the services of that center (the Medicare utilization rate). 42 C.F.R. §§ 405.402(b)(3) and 405.452(b)(1).

25. From its inception, the Medicare program has required each provider to accumulate all of its overhead or "administrative and general" ("A and G") costs in "A and G" cost centers. These A and G cost centers included costs such as those of admission offices, billing departments, legal and accounting services, and pastoral care as well as all insurance costs, including fire, casualty, accident, malpractice insurance premiums or contributions to self-insurance funds.

26. By allocating the A and G costs to revenue-producing cost centers which are reimbursed on the basis of the percentage of Medicare utilization, the Medicare

program has consistently reimbursed these costs in the same manner as all other costs, *i.e.*, in proportion to the utilization by Medicare patients of the provider's services.

27. The regulation for the reimbursement of malpractice costs (the "malpractice regulation"), challenged herein, was promulgated on June 1, 1979, effective for cost reporting periods beginning after June 30, 1979. It establishes a "unique exception" to the traditional utilization approach to the allocation of costs between Medicare and non-Medicare patients. 44 Fed. Reg. 31641-31642.

28. The regulation removes malpractice insurance costs from the A and G pool of costs subject to traditional cost finding and apportionment based on actual Medicare utilization of services. It requires, instead, that they be "directly" apportioned between Medicare and non-Medicare patients "based on the dollar ratio of the provider's Medicare paid malpractice losses to its total paid malpractice losses for the current cost reporting period and the preceding four-year period." 44 Fed. Reg. 31642.

29. A provider with no malpractice losses whatsoever for the five-year period is reimbursed in accordance with the "national ratio of malpractice awards paid to Medicare beneficiaries to malpractice awards paid to all patients." *Id.* The preamble to the regulation establishes the "national ratio" at 5.1%. *Id.*

30. The malpractice regulation effects a radical departure from the principle that overhead costs be apportioned among payors based on their use of the actual services provided.

31. Under the malpractice regulation, a hospital such as Miami Valley Hospital, with no malpractice paid claims of *any* kind for the relevant five-year period, is reimbursed only 5.1% of its malpractice premium costs, despite the fact that Medicare patients used approximately 33% of its services during its cost year ending 1980. The resulting

decrease in Medicare reimbursement for this hospital for one cost year alone is more than $408,800.

32. A provider with only one paid claim, a non-Medicare patient claim, is reimbursed by Medicare under the new regulation for *none* of its malpractice premium costs, despite the fact that hospitals such as plaintiffs provide from 19% to 50% of their services to Medicare patients. The corresponding percentage of malpractice premiums in such hospitals is directly and exclusively attributable to Medicare patient-days.

33. A provider with only one paid claim during the five-year period is paid 100% of its malpractice premium costs if the paid claim relates to a Medicare patient.

34. The result of this regulatory scheme is that a few providers are overreimbursed, and many providers are significantly underreimbursed for their malpractice premium costs. The adverse effect is intensified because of the inability of an individual provider to determine or predict its loss experience and resulting reimbursement levels.

35. Malpractice insurance rates for plaintiffs are set on a patient-day or patient-visit basis, without regard to whether a patient is a Medicare patient.

36. Other third-party cost-reimbursement payors do not reimburse malpractice premium costs on a "paid claims" basis; rather, they reimburse approximately that percentage of malpractice costs which represents their insureds' utilization of hospital patient days.

37. The malpractice regulation results in reimbursement which bears no relationship to premium "costs actually incurred" with respect to Medicare beneficiaries; it creates significant inequities among providers; and it seriously undermines the financial stability of providers, whose Medicare reimbursement rate can fluctuate wildly depending on paid claims.

DEVELOPMENT OF THE MALPRACTICE REGULATION

38. The Medicare statute was enacted as part of the Social Security Amendments of 1965, P.L. 89-97. After protracted negotiations with provider representatives, consultation with other third-party payors, and extensive review by both the Health Insurance Benefits Advisory Council and the Senate Finance Committee, the Secretary issued the Medicare reimbursement regulations on November 23, 1966. 31 Fed. Reg. 14808. Since the inception of the program, the principles of cost-finding and cost apportionment have remained fundamentally unchanged.

39. A Notice of Proposed Rulemaking was published on March 15, 1979. 44 Fed. Reg. 15744. The NPRM purported to justify the proposed revision on the ground that the traditional utilization approach "results in Medicare paying for a disproportionate amount of malpractice costs." 44 Fed. Reg. at 15745.

40. The sole support for this conclusion of the Secretary in the NPRM was a reference to an unidentified "study conducted by an HEW consultant [which] indicates that malpractice awards for Medicare . . . patients are significantly lower in amount than losses for other patient population [*sic*]." 44 Fed. Reg. 15745.

41. Nowhere in the NPRM did the Secretary identify the study which formed the basis for his proposal.

42. The NPRM did not describe the study's methodology, offer to make the study available to commentors, or provide any information to enable commentors to assess the reliability of the study's findings.

43. Contrary to the mandate of Executive Order 12044 that agencies allow the public at least a 60-day comment period for proposed regulations, 43 Fed. Reg. 12661 (March 23, 1978), the notice allowed only 45 days, "[b]ecause of [HEW's] interest in making these regulations effective for cost reporting periods beginning on or after July 1, 1979." 44 Fed. Reg. at 15745. The NPRM stated

that "[i]n our view, this proposal is not complex and 45 days should provide an adequate opportunity for interested parties to analyze it and submit comments." *Id.*

44. HEW ultimately abandond its attempt to circumvent the requirements of E.O. 12044 by publishing on May 1, 1979, a notice reopening the comment period for an additional 15 days. 44 Fed. Reg. 25476.

45. The Deputy General Counsel for Regulation Review reported to the Office of the Secretary before publication of the final rule that the regulation's preamble was neither adequate nor clearly written; further, HCFA received some 450 public comments on the NPRM. All of the public comments opposed the proposed regulations. Therefore we believe that HCFA needs to carefully explain why it is rejecting the public comments.

46. Approximately 600 comments on the proposed rule were submitted by health care institutions, consumers, major accounting firms, insurance companies, risk managers, nurses, health care consultants, actuaries, physicians, and Medicare beneficiaries.

47. The 600 comments included those which pointed out the defects in the statistical validity of the Westat report; challenged the Secretary's assumption that an individual provider's paid claims history determines the amount of malpractice insurance premium cost actually incurred; questioned whether the rule accurately apportions malpractice expenses; explained that the administrative burdens of obtaining the information needed to implement the rule were significant, and in some cases insurmountable; objected to the unfairness of requiring discrete-costing of malpractice insurance premiums while the Secretary consistently refused to permit discrete-costing of administrative costs which are solely or primarily Medicare-related; and challenged the legality of the proposed rule under the Medicare statute.

48. On June 1, 1979, HEW published the regulation in final form. 44 Fed. Reg. 31641-42. The Secretary acknowledged that "[a]ll comments received were against the proposal and recommended that [HEW] withdraw it entirely." *Id.* at 31642.

49. The preamble, which had been determined by the Secretary's own counsel to be inadequate, nonresponsive, and poorly written was published *verbatim*.

50. The rulemaking record contains no evidence that the Secretary seriously considered the great majority of the issues raised by the comments in promulgating the final rule.

51. The Secretary's staff identified at least 19 major categories of issues raised by the comments.

52. The comments which highlighted the serious defects in the sole basis for the regulation (the Westat study) were not even evaluated during the rulemaking process.

53. Although the author of the regulation proposal was asked to respond on May 8, 1979, to major comments questioning the validity of the Westat study, he failed to do so until July 5, 1979, more than a month after the final regulation was issued.

54. The preamble addresses only four of the numerous criticisms raised by the comments, and those responses are conclusory and inadequate. The preamble fails to acknowledge or discuss the remainder.

55. Internal agency documents demonstrate that the stated rationale for the regulation is untrue.

56. The 5.1% "national ratio" which appeared in the final regulation was not discussed in the proposed rule.

57. The rulemaking record contains no evidence that the Secretary conducted any study or survey of the principles generally applied by other third-party payors in reimbursing the costs of malpractice insurance.

THE WESTAT STUDY

58. The study referred to in the NPRM is that performed by Westat, Inc., under PHS Contract 282-76-TQ-0497 and published as *Medical Malpractice Closed Claim Study—1976.*

59. The data collected and analyzed in the study were recorded on magnetic tapes pursuant to section I.C. 10 of PHS Contract 282-76-TQ-0497.

60. The Westat study report is the sole basis cited in the NPRM or final regulation for the conclusion that the Medicare program had overreimbursed hospitals for malpractice insurance costs under the traditional methodology.

61. The Westat study report is the sole basis cited for the final regulation's conclusion that the Medicare program had overreimbursed hospitals for malpractice insurance costs under the traditional methodology.

62. The Westat study report is the sole basis cited in the final regulation or NPRM for the 5.1% "national ratio."

63. The Westat study is not a suitable factual basis for any generalizations about hospital malpractice claims by Medicare patients.

64. Rather than support a radical revision of reimbursement methodology, the Westat data, analyzed properly, demonstrate that the traditional methodology is appropriate and accurately reimburses Medicare providers.

65. The Westat study "sample" was heavily biased by the inclusion of claims against physicians.

66. Claims against hospitals represented only 20% of the claims dollars in the data base.

67. Physician defendants accounted for only 4.4% of total dollars paid on behalf of Medicare patients and 9.2% of total claims by Medicare patients.

68. Hospitals accounted for 17.8% of dollars paid on behalf of Medicare patients and 19.9% of claims by Medicare patients in the Westat data base.

69. HEW itself estimated malpractice premiums reimbursed by medicare during the relevant time period to be only 20% in its synopsis of the Westat Study titled *Medical Malpractice Claims: A Synopsis of the HEW/Industry Study of Medical Malpractice Insurance Claims.*

70. In evaluating the data of the Westat study for purposes of the regulation proposal, the Secretary mismatched statistics: the Westat data related to incidents in medical care provided primarily in 1973 and, therefore, does not correlate with Medicare expenditure data from much later time periods.

IMPACT ON PROVIDERS

71. Because Medicare reimbursement represents a large part of the revenues of hospitals with significant Medicare utilization, their financial viability is very sensitive to Medicare reimbursement fluctuations.

72. Insurers do *not* set hospital insurance rates based on patient age or source of payment (Medicare status); neither do third-party payors reimburse insurance costs on those bases.

73. As a result, non-Medicare patient charges will have to be increased to make up the deficit, a classic example of cost-shifting explicitly prohibited by the Medicare statute.

EFFECT OF THE REGULATION

75. The malpractice regulation singles out malpractice insurance costs from all other hospital costs for special treatment, with no rational basis for so doing.

76. The malpractice regulation leads to incongruous and unfair reimbursement consequences.

77. Under the malpractice regulation, providers such as plaintiffs are grossly under-reimbursed for those portions of their medical malpractice premiums and self-insurance fund contributions incurred in the care of Medicare patients.

78. Non-profit providers, such as plaintiffs, must increase charges to non-Medicare patients to cover the unreimbursed costs of care to Medicare patients.

79. The malpractice regulation results in reimbursable amounts which bear no relationship to premium costs actually incurred with respect to Medicare beneficiaries.

COUNT I

80. Plaintiffs restate, reallege, and incorporate by reference paragraphs 1 through 79 as if more fully set forth herein.

81. The challenged malpractice regulation is procedurally defective, in that it was promulgated without compliance with the notice and comment requirements of the Administrative Procedure Act, 5 U.S.C. § 553, for the following reasons:

a. The notice of proposed rulemaking failed to provide sufficient information for meaningful comment;

b. The final rule included a material provision (the 5.1% "national ratio") neither presented nor suggested by the notice of proposed rulemaking;

c. The basis and purpose statement of the malpractice regulation demonstrated the Secretary's failure to consider major relevant factors raised by public comments and the internal HHS review process;

d. The Secretary failed adequately to respond to public comments;

e. The Secretary was irrevocably committed to promulgating the malpractice regulations and the resulting

rulemaking proceeding totally deprived providers, including plaintiffs, of due process.

COUNT II

82. Plaintiffs restate, reallege, and incorporate by reference paragraphs 1 through 79 as if more fully set forth herein.

83. The defendant's promulgation of the malpractice regulation was arbitrary, capricious, and an abuse of discretion within the meaning of the Administrative Procedure Act § 706(2)(A), 5 U.S.C. § 553, because:

a. its stated purpose was to remedy an *assumed* existing malapportionment of malpractice insurance costs, but no such malapportionment exists or was shown to exist—the sole basis cited for the regulation, the Westat study, does not measure hospital loss experience for Medicare patients and provides no factual support for the assumption underlying the regulation;

b. the "national ratio" was grossly miscalculated—when only *hospital* claims experience is analyzed in the Westat data base, the "national ratio" increases to approximately 17%, as opposed to the 5.1% adopted by the Secretary;

c. the application of direct apportionment only to costs favorable to the Secretary is inequitable and destroys the integrity of the Medicare cost-finding system;

d. the rule has incongruous reimbursement effects which threaten the financial stability of providers because reimbursement is not rationally related to the malpractice premium costs incurred;

e. the regulation is contrary to sound public policy because it encourages manipulation of malpractice claims settlements.

COUNT III

84. Plaintiffs restate, reallege, and incorporate by reference paragraphs 1 through 79 as if more fully set forth herein.

85. The malpractice regulation violates the Medicare statute, specifically 42 U.S.C. § 1395x(v)(1)(A), because it fails to reimburse "reasonable cost" in the following respects:

a. The "paid claims" basis of the regulation fails to reimburse those providers, including plaintiffs, for the reasonable malpractice premium costs "actually incurred" with respect to Medicare beneficiaries, as those premium costs are determined through the processes actually used by insurers, including plaintiffs' insurers;

b. The use of the purported "national average" in lieu of actual "paid claims" experience fails to reimburse individual providers for the premium costs "actually incurred";

c. The regulation shifts costs of care provided to Medicare patients from the Medicare program to non-Medicare patients;

d. The regulation was promulgated without consideration of the principles generally applied by national organizations or other third-party payors;

e. By directly apportioning malpractice costs for reimbursement while requiring that all other A & G costs remain in the indirect cost pool to be apportioned on the basis of utilization, the regulation destroys the integrity of the averaging process which is central to the cost finding and apportionment system, and results in the underreimbursement of the remaining indirect costs.

COUNT IV

86. Plaintiffs restate, reallege, and incorporate by reference paragraphs 1 through 79 as if more fully set forth herein.

87. To the extent that the direct apportionment concept embodied in the challenged regulation is not *per se* violative of the reimbursement provisions of the Medicare statute, it is violative of the Medicare statute as applied. The regulation purports to apply the direct apportionment methodology to all malpractice insurance costs, even to those costs which are fixed. Direct apportionment based on paid loss experience may be applied only to that portion of malpractice insurance costs which are, like the regulation methodology, based on paid loss experience.

COUNT V

88. Plaintiffs restate, reallege, and incorporate by reference paragraphs 1 through 79 as if more fully set forth herein.

89. The decision of the Provider Reimbursement Review Board that it was without jurisdiction with respect to Bethesda Hospital and Deaconess Hospital because the providers had claimed malpractice costs under the methodology dictated by the new regulation and instructions is contrary to the law in the following respects:

(a) 42 U.S.C. § 1395oo(a) affords a provider the right to a "hearing with respect to [its] cost report" if it is "dissatisfied with a final determination" of its fiscal intermediary with respect to the "amount of total program reimbursement due to the provider for the items and services furnished" to Medicare beneficiaries;

(b) Nothing in the language of 42 U.S.C. § 1395oo(a) prohibits the Board from taking jurisdiction over a claim by a provider who followed mandated cost reporting procedures but who raised those issues with the Board and has not been fully reimbursed for services rendered to Medicare beneficiaries;

(c) 42 U.S.C. § 1395oo(d) confers upon the PRRB jurisdiction over reimbursement "matters" covered by the

entire cost report "even though such matters were not considered by the intermediary in making such a final determination;"

(d) The Board's denial of jurisdiction violates the intent of Congress.

COUNT VI

90. Plaintiffs restate, reallege, and incorporate by reference paragraphs 1 through 79 as if more fully set forth herein.

91. The Board's final decision denying jurisdiction with respect to Bethesda Hospital and Deaconess Hospital is contrary to defendant's own regulations in the following respects:

(a) Neither 42 C.F.R. § 405.1835 nor § 405.1839 establishes "intermediary adjustments" as a predicate to the Board's jurisdiction to review Medicare reimbursement matters.

(b) Nothing in the defendant's regulations requires that intermediary adjustments be made only in the Notice of Program Reimbursement.

92. Plaintiffs restate, reallege, and incorporate by reference paragraphs 1 through 79 as if more fully set forth herein.

93. The Board's final decision in this case operates to deny plaintiffs due process of law under the Fifth Amendment to the Constitution of the United States, for the following reasons:

(a) Review by the Board is the sole avenue provided by the Medicare statute for adjudication of provider's reimbursement claims;

(b) Absent a clear indication that Congress intended to limit its jurisdiction, the Board should not limit its range of inquiry to deny providers the right to be heard with respect to unreimbursed costs arising from services rendered to Medicare beneficiaries.

WHEREFORE, the plaintiffs pray:

a. for a declaration by this court that the malpractice regulation is arbitrary, capricious, and an abuse of the Secretary's discretion, and is therefore substantively invalid under 5 U.S.C. § 706(2)(A);

b. for a declaration by this court that the malpractice reguiation is inconsistent with the Medicare statute, specifically 42 U.S.C. § 1395x(v)(1)(A);

c. for a declaration by this court that the malpractice regulation was promulgated in violation of the notice and comment procedures of 5 U.S.C. § 553;

d. for an order enjoining the defendant and her officers, agents, and employees from applying, enforcing, relying on, or otherwise effectuating the provisions of the rule unless and until the Secretary complies fully with the procedure requirements imposed by law;

e. for a declaration by this court that (1) the defendant illegally applied the malpractice regulation in determining the plaintiffs' reimbursement for the cost years at issue and that (2) plaintiffs are entitled to be reimbursed for its malpractice costs in accordance with the cost apportionment rules in effect for all other administrative and general costs, or in the alternative, that direct apportionment applies only to that part of the premium that actually varies based on individual hospital loss experience; or, in the alternative, for a declaration that the statute requires that providers be permitted to directly apportion costs demonstrably under-reimbursed by Medicare;

f. for a declaration by this court that the Provider Reimbursement Review Board had jurisdiction over the cost year ending 1980 for Bethesda Hospital and Deaconess Hospital, and that those providers' 1980 cost years are properly before this court;

g. for an order of this court awarding plaintiffs the sums due, together with interest thereon as provided by law;

h. for costs of suit incurred by plaintiffs; and

i. for such other relief as this court may deem appropriate.

Respectfully submitted,

/s/ BARBARA SCOTT BISON
Barbara Scott Bison

/s/ ROBERT S. BROMBERG
Robert S. Bromberg
PAXTON & SEASONGOOD
1700 Central Trust Tower
Cincinnati, Ohio 45202
(513) 352-6798

/s/ JOHN T. WARD
John T. Ward

/s/ LEONARD C. HOMER
Leonard C. Homer

/s/ MARGARET M. MANNING
Margaret M. Manning
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1600 Maryland National Bank Bldg.
Baltimore, Maryland 21202
(301) 685-1120

Attorneys for Plaintiffs

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF OHIO
WESTERN DIVISIONS

Civil No. C-1-83-0622

BETHESDA HOSPITAL, ET AL., PLAINTIFFS,

v.

MARGARET M. HECKLER, SECRETARY OF HEALTH AND HUMAN SERVICES, DEFENDANT.

(Filed Dec. 2, 1983)
Judge S. Arthur Spiegel

ANSWER

Defendant by and through her undersigned counsel, answers the plaintiffs' complaint as follows:

First Defense

The complaint fails to state a claim upon which relief may be granted.

Second Defense

Plaintiffs Bethesda Hospital and Deaconess Hospital failed to raise their claim for reimbursement in their cost reports and thus are not properly before this Court. This Court is without jurisdiction to hear their appeals.

Third Defense

The defendant answers each of the numbered paragraphs in the plaintiffs' complaint as follows:

1. Admitted.
2. Admitted.

3. Defendant admits that this case arises under the Medicare Act. The defendant denies that the Administrative Procedure Act, 5 U.S.C. § 551 *et seq.* or the Declaratory Judgment Act, 28 U.S.C. § 2201 afford this Court any basis for jurisdiction to review the actions of the Secretary of Health and Human Services in the circumstances described in this case.

4. Defendant admits that the sole jurisdiction of the Court to review the actions of the Secretary is that jurisdiction which is conferred by the Medicare Act itself, specifically 42 U.S.C. § 1395oo(f), as amended by section 955 of the Omnibus Reconciliation Act of 1980. The defendant denies that this Court has jurisdiction under 28 U.S.C. § 1331.

5. Admitted.

6. Admitted, except to deny that the Medicare program is an insurance program in any way governed by general principles of insurance law.

7. Paragraph 7 contains plaintiffs broad characterization of the "provider agreements" entered into between the Secretary and hospitals seeking to participate in the Medicare program and to which no answer is required. The Court is respectfully referred to the full text of these agreements and to the provisions of the Medicare Act upon which they are based for the complete meaning thereof. The defendant affirmatively states that these agreements are voluntarily entered into by the many providers seeking the advantages of the Medicare program.

8-9. Paragraphs 8 and 9 contain plaintiffs' characterization of one section of the Medicare Act dealing with the determination of "reasonable costs" and not averments of fact to which an answer may be required. The Court is respectfully referred to the full text of that section and to other sections of the Act for a complete statement of their contents.

10. The defendant admits that she has been charged with the authority and responsibility by Congress to implement the Medicare Act through regulation. The Court is respectfully referred to the full text of those regulations and to the interpretive manuals and other guidelines which the Secretary has issued for the complete contents thereof.

11. Admitted.

12. The defendant is without knowledge or information sufficient to form a belief as to the first sentence of this paragraph. The defendant admits the second sentence with the qualification that such malpractice insurance costs are considered allowable Medicare expenses solely within the meaning of 42 CFR 405.452(b)(1)(ii).

13. The defendant is without knowledge or information sufficient to form a belief as to the allegations contained in this paragraph. To the extent that an answer may be required, the defendant denies that a hospital's obligations under a bond indenture or other indebtedness is relevant to the validity of the Secretary's malpractice regulation.

14-15. The defendant is without knowledge or information sufficient to form a belief as to the truth of the allegations contained in these paragraphs.

16. The defendant is without knowledge or information sufficient to form a belief as to why or on what theory plaintiffs Bethesda Hospital and Deaconess Hospital failed to "step down" the costs of their malpractice insurance in such way as to perfect their claim for appeal to the Provider Reimbursement Review Board. The defendant affirmatively avers that absent a disallowance on the cost report, these two plaintiffs failed to raise their claim to the PRRB and are not now properly before this Court.

17-18. Admitted.

19. The defendant admits that the documents mentioned in this paragraph were filed before the Provider Reimbursement Review Board but denies that the documents originally identified in Volume II, Attachment C are relevant and admissible with respect to the issues that are raised in this litigation.

20. The defendant admits that the sole issue before this Court is the validity of the Secretary's malpractice insurance cost regulation and affirmatively states that the standard this Court must use in reviewing that regulation is whether, based upon the information that was before the Secretary at the time the regulation was promulgated, the regulation is reasonable and consistent with the Medicare statute.

21. The defendant is without knowledge or information sufficient to form a belief as to the truth of the allegations contained in this paragraph.

22. Admitted, except to deny that plaintiffs Bethesda Hospital and Deaconess Hospital are properly before this Court.

23-24. Paragraphs 23 and 24 contain plaintiffs' conclusions of law and not averments of fact to which an answer may be required. The Court is respectfully referred to the full text of the cited regulations for a complete statement of their contents.

25. Paragraph 25 contains plaintiffs' characterization of the application of the Secretary's regulation concerning general and administrative costs and to which an answer is not required. The Court is respectfully referred to the full text of this regulation for a complete statement of its contents. The defendant denies that the examples cited by the plaintiffs in this paragraph are the only examples of such general and administrative costs.

26. The defendant admits that as a general rule a utilization-based formula has been the basis for the determination of most Medicare reimbursement in stepping down the costs of revenue producing cost centers under Medicare. The defendant denies any implication that the utilization method was the only method available to the Secretary or the only method permitted by law.

27. The defendant admits the first sentence of this paragraph. With respect to the second sentence, the defendant admits only that the words cited by the plaintiffs appear in the preamble to that regulation and the Court is respectfully referred to the full text of that Notice of Proposed Rulemaking for a complete statement of its contents.

28. Paragraph 28 contains plaintiffs' characterization of the Secretary's malpractice insurance cost regulation and not an averment of fact to which an answer may be required. The Court is respectfully referred to the full text of the cited regulation for a complete statement of its contents.

29. The defendant admits only that in the example given, a hospital voluntarily participating in the Medicare program, having experienced no malpractice loss during the five year period required under the malpractice regulation, will receive 5.1% of its malpractice insurance costs as Medicare reimbursement.

30. Denied.

31. The defendant is without knowledge or information sufficient to form a belief as to the actual malpractice loss experience or Medicare utilization of the plaintiff hospitals.

32. The defendant admits that a hospital having experienced only *non-Medicare* related malpractice losses, will receive no reimbursement for the costs of its malpractice insurance since the hospital has experienced no cost which is related to Medicare as that expression is used in the Medicare Act.

33. For the inverse of the same reason as expressed in the defendant's answer to paragraph 37, the defendant admits that a hospital having experienced only *Medicare-related* malpractice losses will receive 100% of its malpractice insurance costs as Medicare reimbursement.

34. Denied.

35. The defendant denies the relevancy of this allegation.

36. The defendant denies the relevancy of the allegation contained in this paragraph even if taken as true.

37. Denied.

38. Paragraph 38 contains plaintiffs characterization of certain aspects of the Medicare program and conclusions of law thereon to which no answer is required. The Court is respectfully referred to the full text of the Act for a complete statement of its contents. The last sentence of this paragraph is denied.

39. Admitted, except to deny any connotation attributed to the word "purported" as used in this paragraph.

40. Denied, except to admit that the regulation was based on the Secretary's stated conclusion that Medicare patients were the cause of a significantly lower ratio of malpractice losses.

41-42. Denied, except to admit that the study was widely known and identified to the general public and was specifically addressed by several commentors, including major hospital trade associations.

43. Denied, except to admit that the NPRM called for a 45-day comment period.

44. Denied, except to admit that on May 1, 1979 the Secretary approved a 15-day extension of the comment period, to May 15, 1979.

45. Denied, except to admit that the named official did indicate an opinion that a more detailed preamble would be preferred.

46. The defendant admits that hundreds of comments were received during the comment period and positively avers that this demonstrates the adequacy of the public notice and comment period and the awareness in the gen-

eral community and in the hospital industry as to the contents of the Secretary's regulation, its basis and purpose.

47. Denied, except to admit that the Secretary received comments containing various criticisms of the proposed regulations, including challenges to the Westat Report and to the Secretary's conclusions resulting at least partially from that report. The Court is respectfully referred to the full text of the various comments received by the Secretary in response to the NPRM for the full and complete contents thereof. The defendant affirmatively avers that the comments do indicate the public awareness of and response to the Westat Report.

48. Admitted.

49. Denied, except to admit that the final preamble was the same as circulated among Department officials for comment.

50. Denied, except to admit that on June 1, 1979, the final regulation was published including an extensive preamble which outlined the Secretary's purposes in promulgating the regulation and which discussed the public reaction to the proposal.

51. Denied, except to admit that officials of the Department closely reviewed the many comments received during the comment period, thus demonstrating the depth of consideration given to this regulation by the Secretary and her staff.

52. Denied.

53. Denied, except to admit that a response to a request for comment was received on July 5, 1979.

54. Denied.

55. Denied.

56. Denied.

57. Denied, except to admit that the Secretary is not bound by third party insurance practices and accounting procedures.

58. Admitted.

59. Admitted.

60. Denied.

61. Denied.

62. Denied, except to admit that the 5.1% was derived from the nearly universal statistical sample accumulated as part of the Westat Report.

63. Denied.

64. Denied.

65. Denied.

66-68. Denied, except to admit that the figures stated by the plaintiffs are estimated from statistics contained in the Westat study.

69. Denied.

70. Denied.

71. Paragraph 71 represents plaintiffs' characterization of the impact of Medicare reimbursement on an individual hospital's "financial viability." The defendant is without knowledge or information sufficient to form an opinion as to any individual hospital and would admit only that Medicare currently accounts for up to 40 percent of the revenues of the average hospital and that many individual hospitals may be higher or lower than that average.

72. Denied and the defendant affirmatively states that the Medicare program is not bound by the premium-setting practices of malpractice insurance companies nor is it required to follow the third-party payment practices of the private health insurance industry. Plaintiffs' inference drawn from these erroneous assumptions are totally incorrect.

73. Denied.

74. [Plaintiffs' Complaint Has No Paragraph #74].

75. Denied.

76. Denied.

77. Denied.

78. Denied.

79. Denied.

80. The defendant reiterates and incorporates by reference herein, the answers she has already given to paragraphs 1 through 79 of the Complaint.

81. Denied.

82. The defendant reiterates and incorporates by reference herein, the answers she has already given to paragraphs 1 through 81 of the Complaint.

83. Denied.

84. The defendant reiterates and incorporates by reference herein, the answers she has already given to paragraphs 1 through 83 of the Complaint.

85. Denied.

86. The defendant reiterates and incorporates by reference herein, the answers she has already given to paragraphs 1 through 85 of the Complaint.

87. Denied.

The defendant hereby specifically denies all allegations, inferences and conclusions contained in the Complaint which have not here before been otherwise answered.

Fourth Defense

The Court lacks jurisdiction over the subject matter of this action to the extent that the plaintiff seeks any determination, finding or order of this Court other than as to the legal sufficiency and validity of the Secretary's regulation concerning Medicare reimbursement for the costs of malpractice insurance.

WHEREFORE the defendant asks that judgment be entered dismissing the complaint and affirming the validity of the challenged regulation and such other and further relief as the Court may deem appropriate.

Respectfully submitted,

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United States Attorney

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CERTIFICATE OF SERVICE OMITTED IN PRINTING.

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF OHIO
WESTERN DIVISION
Title omitted in printing.

Plaintiffs' Opposition To
Defendant's Second Motion To Dismiss
Attachment B-1

Excerpts from FYE 1980 Cost Report
BETHESDA HOSPITAL

Form Approved
OMB No. 68-R0078

WORKSHEET CHECKLIST FOR HOSPITAL, HOSPITAL-SKILLED NURSING FACILITY COMPLEX AND SKILLED NURSING FACILITY COST REPORT

PROVIDER NO: 36-0193 PERIOD: FROM January 1, 1980 TO December 31, 1980

	CHECK THE APPROPRIATE COLUMN FOR EACH WORKSHEET	Completed		
		HCFA Worksheet	Submitted Worksheet	Not Applicable
	WORKSHEETS	1	2	3
1	Worksheet Checklist			
2	Hospital and Hospital-Skilled Nursing Facility Complex and Skilled Nursing Facility Statistical Data – Part I	X		
3	Hospital and Hospital-Skilled Nursing Facility Complex and Skilled Nursing Facility Statistical Data – Parts II and III			
4	Hospital and Hospital-Skilled Nursing Facility Complex and Skilled Nursing Facility Statistical Data – Parts IV and V			X
5	Worksheet A		X	
6	Worksheet A-1		X	
7	Worksheet A-2			X
8	Worksheet A-3			X
9	Worksheet A-4			X
10	Worksheet A-5			X
11	Worksheet A-6		X	
12	Worksheet A-7	X		
13	Worksheet A-8		X	
14	Worksheet A-8-1	X		
15	Worksheet A-8-2	X		
16	Worksheet B		X	
17	Worksheet B-1		X	
18	Worksheet C		X	
19	Worksheet D		X	
20	Worksheet D-1 – Part I (All Pages Must Be Completed)		X	
21	Worksheet D-1 – Part II		X	
22	Worksheet D-2			X
23	Worksheet D-3		X	
24	Worksheet D-6		X	
25	Worksheet E – Part I – Modified	X		
26	Worksheet E – Part II – Modified	X		
27	Worksheet E – Part III – Modified	X		
28	Worksheet E-1	X		
29	Worksheet E-2 – Modified	X		
30	Worksheet E-5 – Parts I and II			X
31	Worksheet E-5 – Part III			X
32	Worksheet G	X		
33	Worksheet G-1	X		
34	Worksheet G-2	X		
35	Worksheet G-3	X		

SUPPLEMENTAL WORKSHEETS (AVAILABLE UPON REQUEST FROM INTEMEDIARY):

36	HCFA-2552A – Supplemental Worksheet D-4			
37	HCFA-2552A – Supplemental Worksheet D-5			
38	HCFA-2552B – Supplemental Worksheet D-8			
39	HCFA-2552C – Supplemental Worksheet D-7			
40	HCFA-2552D – Supplemental Worksheet E-3			
41	HCFA-2552E – Supplemental Worksheet E-4			
42	HCFA-2552F – Supplemental Worksheet E-4-1			
43	HCFA-2552G – Supplemental Worksheet F – Part I			
44	HCFA-2552G – Supplemental Worksheet F – Part II			
45	HCFA-2552G – Supplemental Worksheet F – Part III			
46	HCFA-2552H – Supplemental Worksheet A-8-3			

Supplemental Worksheets H, I, J, K, L, M, N, P, Q, X

If substitute worksheets are a part or all of this cost report (a check in column 2), enter the name and address of the person, company forms preparation service which originated the substitute worksheet(s):

NAME : Ernst & Whinney

ADDRESS: 2400 Nationwide Plaza

Columbus, Ohio 43215

Form HCFA-2552 (5-80)
Destroy old stock

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This report is required by law (42 USC 1395g, 20 CFR 405.406(b)). Failure to report can result in all reasonable payments under Title XVIII during the cost report period being deemed overpayments (42 USC 1320a-3).

Form Approved
OMB No. 68-R0178

HOSPITAL, HOSPITAL-SKILLED NURSING FACILITY COMPLEX AND SKILLED NURSING FACILITY STATISTICAL DATA

INTERMEDIARY USE ONLY
☐ AUDITED ☐ DESK REVIEWED

DATE RECEIVED

INTERMEDIARY NO.

PART I – GENERAL

1. Names and Addresses	Provider Number/s	Dates Certified
HOSPITAL: BETHESDA HOSPITAL	36-0193	7/66
SUBPROVIDER I:		
SUBPROVIDER II:		
SKILLED NURSING FACILITY:		
HOME HEALTH AGENCY:		
SPECIAL PROVIDER-CONTROLLED FACILITY:		

2. Cost Reporting Period From January 1, 1980 To December 31, 1980

3. Type of Control

a. Voluntary Hospital:
☐ Church
☒ Other (Specify)

b. Proprietary:
☐ Individual ☐ Partnership
☐ Corporation ☐ Other (Specify)

c. Government:
☐ Federal ☐ State ☐ Other (Specify)
☐ City-County ☐ Hospital District
☐ County ☐ City

4. Type of Hospital

a.
☒ General-Short Term ☐ Specialty Long-Term
☐ General-Long Term ☐ Chronic Disease
☐ Tuberculosis ☐ Psychiatric
☐ Specialty Short-Term ☐ Other (Specify)

b. Medicare Certified Kidney Transplant Hospital: ☐ Yes ☐ No

5. Type of Skilled Nursing Facility

☐ Entirely Certified Skilled Nursing Facility
☐ Partially Certified Skilled Nursing Facility
☐ Skilled Nursing Facility Unit of Domiciliary Institution
☐ Skilled Nursing Facility Unit of Rehabilitation Center
☐ Other (Specify)

6. Health Care Programs
☐ Title V ☐ Title XVIII ☐ Title XIX

7.

a. Are management and/or administrative support services purchased from an outside supplier or organization? ☐ Yes ☐ No

b. If yes, what is the total amount for these services as reported in Worksheet A, column 7? $

INTENTIONAL MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above statement and that I have examined the accompanying Statement of Reimbursable Cost and the Balance Sheet and Statement of Revenue and Expenses prepared by THE BETHESDA HOSPITAL ASSOCIATION (PROVIDER NO. 36-0193) (Provider name(s) and number(s)) for the cost report period beginning January 1, 1980 and ending December 31, 1980, and that to the best of my knowledge and belief, it is a true, correct, and complete statement prepared from the books and records of the provider(s) in accordance with applicable instructions, except as noted. (See specific notes included)

We reserve the right to refile this cost report if the manner in which we included the reimbursement for certain controversies is not acceptable for protecting our appeal rights.

(Signed) Joe Reese
Officer or Administrator of Provider(s)
Joe Reese
Title Controller
Date

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37a

SAMST & WHIMMLY KOSTPAK SYSTEM
BETHESDA HOSPITAL PROV # 36-0193 FYE 12/31/90
HOSPITAL AND HOSPITAL-SKILLED NURSING FACILITY COMPLEX
STATISTICAL DATA
SUBMITTED IN LIEU OF HCFA-2552, PAGE 3

RUN DATE: 04/29/91

PART II - HOSPITAL STATISTICS

		SPECIAL CARE UNITS			
	GENERAL SERVICE	ICU	CCU	OTHER (SPECIFY)	
IMPATIENT - ALL PATIENTS	1	2	3	4	5
1 BEDS (EXCLUDING NEWBORN) AVAILABLE AT BEGINNING OF PERIOD	333	10	9	0	0
2 BEDS (EXCLUDING NEWBORN) AVAILABLE AT END OF PERIOD	343	10	9	0	0
3 TOTAL BED DAYS AVAILABLE (EXCLUDING NEWBORN)	121545	3650	3285	0	0
4 AGED, PEDIATRIC AND MATERNITY INPATIENT DAYS	41214	863	994	0	0
5 OTHER THAN AGED, PEDIATRIC AND MATERNITY INPATIENT DAYS (EXCLUDING NEWBORN)	41380	1500	753	0	0
6 TOTAL INPATIENT DAYS (EXCLUDING NEWBORN)	84594	2363	1747	0	0
7 PERCENT OCCUPANCY	69.60%	64.74%	53.18%	0.00%	0.00%
8 TOTAL NEWBORN INPATIENT DAYS	5828	----	----	----	----
INPATIENT - HEALTH CARE PROGRAMS	----	----	----	----	----
9 TITLE V	----	----	----	----	----
A INPATIENT DAYS (EXCLUDING NEWBORN)	0	0	0	0	0
B NEWBORN INPATIENT DAYS	0	----	----	----	----
10 TITLE XVIII	----	----	----	----	----
A AGED, PEDIATRIC AND MATERNITY INPATIENT DAYS (EXCLUDING KIDNEY ACQUISITION DAYS)	27285	758	963	0	0
B KIDNEY ACQUISITION DAYS (AGED, PEDIATRIC, AND MATERNITY)	0	0	0	0	0
C TOTAL AGED, PEDIATRIC, AND MATERNITY INPATIENT DAYS	27285	758	963	0	0
D OTHER THAN AGED, PEDIATRIC AND MATERNITY INPATIENT DAYS (EXCLUDING KIDNEY ACQUISITION DAYS)	4118	117	115	0	0
E KIDNEY ACQUISITION DAYS (OTHER THAN AGED, PEDIATRIC AND MATERNITY)	0	0	0	0	0
F TOTAL OTHER THAN AGED, PEDIATRIC AND MATERNITY INPATIENT DAYS	4118	117	115	0	0
G TOTAL INPATIENT DAYS (EXCLUDING KIDNEY ACQUISITION DAYS)	31703	875	1078	0	0
H TOTAL KIDNEY ACQUISITION DAYS	0	0	0	0	0
I TOTAL PART A INPATIENT DAYS	31703	875	1078	0	0
J TOTAL PART B INPATIENT DAYS	31703	875	1078	0	0
K PART B INPATIENT DAYS WHEN PART A BENEFITS ARE NOT AVAILABLE	0	0	0	0	0
11 TITLE XIX	----	----	----	----	----
A INPATIENT DAYS (EXCLUDING NEWBORN)	0	0	0	0	0
B NEWBORN INPATIENT DAYS	0	----	----	----	----

OUTPATIENT - HEALTH CARE PROGRAMS	TITLE V	TITLE XVIII	TITLE XIX	ALL OTHER	TOTAL
12 NUMBER OF OCCASIONS OF SERVICE (EXCLUSIVE OF RENAL DIALYSIS TREATMENTS)	0	0	0	0	0

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ERNST & WHINNEY KOSTPAN SYSTEM
METHODIST HOSPITAL PROV # 16-0192 FYE 12/31/80 RUN DATE: 04/20/81
HOSPITAL AND HOSPITAL-SKILLED NURSING FACILITY COMPLEX
STATISTICAL DATA
SUBMITTED IN LIEU OF HCFA-2552- PAGE 3 (CONT'D)

PART III - OTHER HOSPITAL DATA

1 AMOUNT OF ACCELERATED PAYMENTS OUTSTANDING AS OF END OF COST REPORTING PERIOD - TITLE XVIII	0	0
2 AVERAGE NUMBER OF EMPLOYEES ON PAYROLL FOR THE PERIOD (FULL-TIME EQUIVALENT) - EXCLUDES NONPAID WORKERS		822
3 AVERAGE NUMBER OF NONPAID WORKERS FOR THE PERIOD (FULL-TIME EQUIVALENT) FOR WHICH REIMBURSEMENT IS CLAIMED		0
4 NUMBER OF RENAL DIALYSIS TREATMENTS (INPATIENT AND OUTPATIENT)		
A TOTAL - ALL HOSPITAL PATIENTS		0
B TITLE V		0
C TITLE XVIII		0
D TITLE XIX		0
5 NUMBER OF ADMISSIONS (EXCLUDING NEWBORN)		
A TOTAL - ALL HOSPITAL INPATIENTS		12711
B TITLE V		0
C TITLE XVIII		3312
D TITLE XIX		0
6 NUMBER OF DISCHARGES INCLUDING DEATHS (EXCLUDING NEWBORN)		
A TOTAL - ALL HOSPITAL INPATIENTS		12711
B TITLE V		
C TITLE XVIII		0
D TITLE XIX		0
7 AVERAGE LENGTH OF STAY		
A TOTAL		6.98
B TITLE V		0.00
C TITLE XVIII		.00
D TITLE XIX		0.00

ERNST & WHINNEY KOSTPAK SYSTEM
BETHESDA HOSPITAL PROV # 36-0193 FYE 12/31/80 RUN DATE: 04/20/81
RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES
SUBMITTED IN LIEU OF HCFA-2552, PAGE 5 WORKSHEET A

EIN CST CTR NUM-BER	HCFA LINE NUM-BER	COST CENTER	SALARIES 1	OTHER 2	TOTAL 3	RECLASSIFICATIONS 4	RECLASSIFIED TRIAL BALANCE 5	ADJUSTMENTS TO EXPENSES 6	NET EXPENSES FOR COST ALLOCATION 7
---	1	GENERAL SERVICE COST CENTERS	---	---	---	---	---	---	---
101	2	DEPRECIATION - BUILDINGS & FIXTURES	---	704935	704935	654762	1359697	0	1359697
102	3	DEPRECIATION - MOVABLE EQUIPMENT	---	526240	526240	0	526240	0	526240
103	4	EMPLOYEE HEALTH & WELFARE	76262	1143180	1219442	776	1220218	-84466	1135752
104	5A	NON-PATIENT TELEPHONES	33314	140545	173859	8000	181859	-25047	156812
105	5B	DATA PROCESSING	81475	59601	141076	0	141076	0	141076
106	5C	PURCHASING RECEIVING STORES	92059	47712	139771	0	139771	-12267	127504
107	5D	ADMITTING	85808	7035	92843	0	92843	0	92843
108	5E	CASHIER ACCOUNT RECEIVABLE COLLECTIONS	340370	120282	460652	0	460652	0	460652
109	5	OTHER ADMINISTRATIVE & GENERAL	264362	444838	709200	-23759	685441	-112890	572551
110	6	MAINTENANCE & REPAIRS	331749	231664	563413	0	563413	-197	563216
111	7	OPERATION OF PLANT	0	486401	486401	0	486401	-2519	483882
112	8	LAUNDRY & LINEN SERVICE	163031	114794	277825	0	277825	-76086	201739
113	9	HOUSEKEEPING	324821	180975	505796	0	505796	0	505796
114	10	DIETARY	513941	884526	1398467	-490335	908132	0	908132
115	11	CAFETERIA	0	0	0	490335	490335	-251513	238822
116	12	MAINTENANCE OF PERSONNEL	0	0	0	0	0	0	0
117	13	NURSING ADMINISTRATION	348081	20824	368905	0	368905	0	368905
118	14	CENTRAL SERVICES & SUPPLY	96837	275476	372313	0	372313	-8860	363453
119	15	PHARMACY	195309	660584	855893	-516493	339400	56799	282601
120	16	MEDICAL RECORDS & LIBRARY	186697	60792	247489	-6894	240595	-5798	234797
121	17	SOCIAL SERVICE	111229	8847	120076	-1938	118138	0	118138
122	18	NURSING SCHOOL	0	0	0	0	0	0	0
123	19	INTERN-RESIDENT SERVICE (APPROVED)	0	0	0	0	0	0	0
124	20	BLANK	0	0	0	0	0	0	0
---	21	ANCILLARY SERVICE COST CENTERS	-----	-----	-----	-----	-----	-----	-----
125	22	OPERATING ROOM	358639	476777	835416	0	835416	-1975	833441
126	23	RECOVERY ROOM	0	0	0	0	0	0	0
127	24	DELIVERY ROOM & LABOR ROOM	188025	43399	231424	13573	244997	0	244997
128	25	ANESTHESIOLOGY	0	28039	28039	0	28039	0	28039
129	26	RADIOLOGY - DIAGNOSTIC	375591	284283	659874	66657	726531	-5446	721085
130	27	CAT SCAN	29176	170571	199747	7741	207488	-103356	104132
131	28	RADIOISOTOPE	35845	50293	86138	3960	90098	0	90098
132	29	LABORATORY	513872	498866	1012738	2992	1015730	-96312	921418
133	30	WHOLE BLOOD AND PACKED RED BLOOD CELLS	0	0	0	0	0	0	0
134	31	BLOOD STORING PROCESSING & TRANSFUSION	69719	45390	115109	0	115109	-146	114963
135	32	INTRAVENOUS THERAPY	0	71762	71762	0	71762	0	71762
136	33	OXYGEN (INHALATION) THERAPY	264982	80268	345250	0	345250	0	345250
137	34	PHYSICAL THERAPY	66144	3668	69812	0	69812	0	69812
138	35	OCCUPATIONAL THERAPY	89330	6187	95517	0	95517	0	95517
139	36	SPEECH PATHOLOGY	20802	6812	27614	0	27614	0	27614
140	37	ELECTROCARDIOLOGY	41689	14030	55719	0	55719	0	55719
141	38	ELECTROENCEPHALOGRAPHY	9290	21588	30878	0	30878	-18320	12558
142	39	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	0	0
143	40	DRUGS CHARGED TO PATIENTS	0	0	0	516493	516493	0	516493
144	41	RENAL DIALYSIS	0	0	0	0	0	0	0
145	42	KIDNEY ACQUISITION	0	0	0	0	0	0	0
146	43	BLANK	0	0	0	0	0	0	0

ERNST & WHINNEY KOSTPAK SYSTEM
BETHESDA HOSPITAL PROV # 36-0193 FYE 12/31/80 RUN DATE: 04/20/81
RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES
SUBMITTED IN LIEU OF HCFA-2552, PAGE 5 (CONT'D) WORKSHEET A

EIW CST CTR NBR	HCFA LINE NUMBER	COST CENTER	SALARIES 1	OTHER 2	TOTAL 3	RECLASSIFICATIONS 4	RECLASSIFIED TRIAL BALANCE 5	ADJUSTMENTS TO EXPENSES 6	NET EXPENSES FOR COST ALLOCATION 7
---	45	INPATIENT ROUTINE SERVICE COST CENTERS	-----	-----	-----	-----	-----	-----	-----
147	46	ADULTS & PEDIATRICS (GEN ROUTINE CARE)	334388	121627	3465516	-24391	3441125	0	3441125
148	47	INTENSIVE CARE UNIT	459544	29014	488558	0	488558	0	488558
149	48	CORONARY CARE UNIT	260126	12345	272471	0	272471	0	272471
150	51	NURSERY	150342	17256	167598	10818	178416	0	178416
151	52	SKILLED NURSING FACILITY - CERTIFIED	0	0	0	0	0	0	0
152	53	SKILLED NURSING FACILITY - NONCERTIFIED	0	0	0	0	0	0	0
153	53A	BLANK	0	0	0	0	0	0	0
---	54	OUTPATIENT SERVICE COST CENTERS	-----	-----	-----	-----	-----	-----	-----
154	55	CLINIC	96781	95852	192633	-5179	187454	-13740	173714
155	56	EMERGENCY	384801	594279	979080	0	979080	-527664	451416
---	58	OTHER REIMBURSABLE COST CENTERS	-----	-----	-----	-----	-----	-----	-----
156	59	HOME PROG. DIALYSIS OTHER	0	0	0	0	0	0	0
157	60	SKILLED NURSING CARE-HHA	0	0	0	0	0	0	0
158	61	MEDICAL SOCIAL SERVICES-HHA	0	0	0	0	0	0	0
159	62	HOME HEALTH AIDE - HHA	0	0	0	0	0	0	0
160	63	OTHER HOME HEALTH SERVICES - HHA	0	0	0	0	0	0	0
161	64	HOME PROG DIALYSIS EQUIP-100% MEDICARE	0	0	0	0	0	0	0
162	65	AMBULANCE SERVICES	0	0	0	0	0	0	0
163	66	INTERNS-RESIDENTS (NOT APPROVED)	0	0	0	0	0	0	0
164	67	MALPRACTICE PREMIUMS & PAID LOSSES	0	0	0	0	0	0	0
165	68	INTEREST EXPENSE	0	720238	720238	-720238	0	0	0
166	69	UTILIZATION REVIEW - SNF	0	0	0	0	0	0	0
167	70	PSRO-FEDERAL OR COMBINED	33868	53	33921	13120	47041	-47041	0
168	71	PSRO - NONFEDERAL	0	0	0	0	0	0	0
---	73	SUBTOTAL	10059800	9491848	19551648	0	19551648	-1450442	18101206
---	74	NONREIMBURSABLE COST CENTERS	-----	-----	-----	-----	-----	-----	-----
169	75	GIFT FLOWER COFFEE SHOPS & CANTEEN	0	0	0	0	0	0	0
170	76	RESEARCH	0	0	0	0	0	0	0
171	77	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	0	0
172	78	NONPAID WORKERS	0	0	0	0	0	0	0
---	80	TOTAL	10059800	9491848	19551648	0	19551648	-1450442	18101206

ERNST & WHINNEY KOSTPAK SYSTEM
BETHESDA HOSPITAL PROV # 36-0193 FYE 12/31/80
ADJUSTMENTS TO EXPENSES
SUBMITTED IN LIEU OF HCFA-2552, PAGE 11

RUN DATE: 04/20/81

WORKSHEET A-8

	DESCRIPTION	BASIS FOR ADJUST-MENT 1	AMOUNT 2	EXPENSE CLASSIFICATION ON WORKSHEET A FROM WHICH THE AMOUNT IS TO BE DEDUCTED OR TO WHICH THE AMOUNT IS TO BE ADDED: COST CENTER 3	HCFA LINE NO. 4	E&W COST CTR NO.
1	INVESTMENT INCOME ON COMMINGLED RESTRICTED AND UNRESTRICTED FUNDS (CHAPTER 2)		$ 0			0
2	TRADE, QUANTITY, TIME AND DISCOUNTS ON PURCHASES (CHAPTER 8)	B	-10992	PURCHASING RECEIVING STORES	5C	106
3	REBATES AND REFUNDS OF EXPENSES (CHAPTER 8)		0			0
4	RENTAL OF PROVIDER SPACE BY SUPPLIERS (CHAPTER 9)		0			0
5	TELEPHONE SERVICE (PAY STATIONS EXCLUDED) (CHAPTER 21)	A	-25047	NON-PATIENT TELEPHONES	5A	104
6	TELEVISION AND RADIO SERVICE (CHAPTER 21)		0			0
7	PARKING LOT (CHAPTER 21)		0			0
8	REMUNERATION APPLICABLE TO PROVIDER-BASED RADIOLOGISTS FOR PROFESSIONAL SERVICES (CHAPTER 21)		0			0
9	REMUNERATION APPLICABLE TO PROVIDER-BASED PATHOLOGISTS FOR PROFESSIONAL SERVICES (CHAPTER 21)	A	-91169	LABORATORY	29	132
10	REMUNERATION APPLICABLE TO PROVIDER-BASED ANESTHESIOLOGISTS FOR PROFESSIONAL SERVICES (CHAPTER 21)		0			0
11	REMUNERATION APPLICABLE TO PROVIDER-BASED CARDIOLOGISTS FOR PROFESSIONAL SERVICES (CHAPTER 21)		0			0
12	REMUNERATION APPLICABLE TO PROVIDER-BASED NEUROLOGISTS FOR PROFESSIONAL SERVICES (CHAPTER 21)	A	-18320	ELECTROENCEPHALOGRAPHY	38	141
13	RADIOLOGY - THERAPEUTIC		0			0
14	RADIOISOTOPE		0			0
15	NUCLEAR MEDICINE		0			0
16	MISC. REVENUES	B	-123	OTHER ADMINISTRATIVE & GENERAL	5	109
17	HOME OFFICE COSTS (CHAPTER 21)		0			0
18	SALE OF SCRAP, WASTE, ETC. (CHAPTER 23)		0			0
19	NONALLOWABLE COSTS RELATED TO CERTAIN CAPITAL EXPENDITURES (CHAPTER 24)		0			0
20	ADJUSTMENT RESULTING FROM TRANSACTIONS WITH RELATED ORGANIZATIONS (CHAPTER 10)		0			0
21	LAUNDRY AND LINEN SERVICE	B	-76086	LAUNDRY & LINEN SERVICE	8	112
22	CAFETERIA - EMPLOYEES, GUESTS, ETC.	B	-251513	CAFETERIA	11	115
23	RENTAL OF LIVING QUARTERS TO EMPLOYEES AND OTHERS	B	-9330	OTHER ADMINISTRATIVE & GENERAL	5	109
24	SALE OF MEDICAL AND SURGICAL SUPPLIES TO OTHER THAN PATIENTS		0			0
25	SALE OF DRUGS TO OTHER THAN PATIENTS	B	-56799	PHARMACY	15	119
26	SALE OF MEDICAL RECORDS AND ABSTRACTS	B	-5062	MEDICAL RECORDS & LIBRARY	16	120
27	NURSING SCHOOL (TUITION, FEES, TEXTBOOKS, UNIFORMS, ETC.)		0			0
28	VENDING MACHINES	B	-2519	OPERATION OF PLANT	7	111
29	INCOME FROM IMPOSITION OF INTEREST, FINANCE OR PENALTY CHARGES (CHAPTER 21)		0			0
30	XEROX SALES	B	-1275	PURCHASING RECEIVING STORES	5C	106
31	PSRO COST	A	-47041	PSRO-FEDERAL OR COMBINED	70	167
32	SUBTOTAL	---	$ -595276			

ERNST & WHINNEY KOSTPAK SYSTEM
BETHESDA HOSPITAL PROV # 36-0193 FYE 12/31/80
ADJUSTMENTS TO EXPENSES
SUBMITTED IN LIEU OF HCFA-2552, PAGE 12

RUN DATE: 04/20/81

WORKSHEET A-8

	DESCRIPTION	BASIS FOR ADJUSTMENT 1	AMOUNT 2	EXPENSE CLASSIFICATION ON WORKSHEET A FROM WHICH THE AMOUNT IS TO BE DEDUCTED OR TO WHICH THE AMOUNT IS TO BE ADDED — COST CENTER 3	HCFA LINE NO. 4	E&W COST CTR NO.
33	SUBTOTAL	---	$ -595276			
34	ADJUSTMENTS FOR PHYSICAL THERAPY COSTS IN EXCESS OF LIMITATION (CHAPTER 14)		0			0
35	MALPRACTICE PREMIUMS AND/OR SELF-INS. FUND CONTRIBUTIONS (CHAPTER 21)	A	-377217	OTHER ADMINISTRATIVE & GENERAL	5	109
36	ALLOWABLE PAID TITLE XVIII MALPRACTICE LOSSES (CHAPTER 21)		0			0
37	ALLOWABLE RELATED DIRECT EXPENSES TO PAID TITLE XVIII MALPRACTICE LOSSES (CHAPTER 21)		0			0
38	ALLOWABLE PAID TITLE XIX MALPRACTICE LOSSES (CHAPTER 21)		0			0
39	ALLOWABLE RELATED DIRECT EXPENSES TO PAID TITLE XIX MALPRACTICE LOSSES (CHAPTER 21)		0			0
40	ALLOWABLE PAID TITLE V MALPRACTICE LOSSES (CHAPTER 21)		0			0
41	ALLOWABLE RELATED DIRECT EXPENSES TO PAID TITLE V MALPRACTICE LOSSES (CHAPTER 21)		0			0
42	ALLOWABLE PAID MALPRACTICE LOSSES AND RELATED DIRECT EXPENSES APPLICABLE TO THE HOME HEALTH AGENCY		0			0
43	NONALLOWABLE MALPRACTICE PREMIUMS, PAID LOSSES AND RELATED EXPENSES (CHAPTER 21)		0			0
44			0			0
45	PSRO COSTS (FEDERAL OR COMBINED) (PRM, PART I, 1975 AMENDMENTS)		0			0
46	PSRO COSTS (NON-FEDERAL ONLY) (PRM, PART I, 1975 AMENDMENTS)		0			0
47	CONT.MED.EDUC.	B	-736	MEDICAL RECORDS & LIBRARY	16	120
48	MISC-MAINTENANCE	B	-197	MAINTENANCE & REPAIRS	6	110
49	MISC-OR	B	-1975	OPERATING ROOM	22	125
50	MISC-BLOOD	B	-146	BLOOD STORING PROCESSING & TRANSFUSION	31	134
51	MISC-LAB	B	-5143	LABORATORY	29	132
52	PATHOLOGIST FRINGES	B	-839	EMPLOYEE HEALTH & WELFARE	4	103
53	MISC-SUPPLY	B	-8860	CENTRAL SERVICES & SUPPLY	14	118
54	RECRUITING COST	B	-12771	OTHER ADMINISTRATIVE & GENERAL	5	109
55	RECRUITING COST	B	-17500	EMPLOYEE HEALTH & WELFARE	4	103
56	SILVER RECOVERY(AT COST)	A	-5446	RADIOLOGY - DIAGNOSTIC	26	129
57	CAT SCAN HBP	A	-103356	CAT SCAN	27	130
57A	ER PHYSICIANS	A	-527664	EMERGENCY	56	155
57B	GAIN ON DISP OF ASSET	B	-949	OTHER ADMINISTRATIVE & GENERAL	5	109
57C	SELF-INS HOSPITAL	A	-66127	EMPLOYEE HEALTH & WELFARE	4	103
57D	PURCHSED LAB SVCS	A	-13740	CLINIC	55	154
57E	MALPRACTICE INS FUNDING	A	287500	OTHER ADMINISTRATIVE & GENERAL	5	109
58	SUBTOTAL	---	$ -1450442			
59	GRANTS, GIFTS, AND INCOME DESIGNATED BY DONOR FOR SPECIFIC EXPENSES (CHAPTER 6)		0			0
60	UTILIZATION REVIEW - PHYSICIANS' COMPENSATION (CHAPTER 21)		0			0
61	DEPRECIATION - BUILDINGS AND FIXTURES		0			0

ERNST & WHINNEY KOSTPAK SYSTEM
BETHESDA HOSPITAL PROV # 36-0193 FYE 12/31/80 RUN DATE: 04/20/81
ADJUSTMENTS TO EXPENSES
SUBMITTED IN LIEU OF HCFA-2552, PAGE 12 (CONT'D) WORKSHEET A-8

	DESCRIPTION	BASIS FOR ADJUST-MENT 1	AMOUNT 2	EXPENSE CLASSIFICATION ON WORKSHEET A FROM WHICH THE AMOUNT IS TO BE DEDUCTED OR TO WHICH THE AMOUNT IS TO BE ADDED — COST CENTER 3	HCFA LINE NO. 4	E&W COST CTR NO.
62	DEPRECIATION - MOVABLE EQUIPMENT		0			0
63			0			0
64	TOTAL	---	$ -1450442	----------		

BASIS FOR ADJUSTMENT
A. COSTS--IF COST, INCLUDING APPLICABLE OVERHEAD, CAN BE DETERMINED.
B. AMOUNT RECEIVED--IF COST CANNOT BE DETERMINED.

43a

14

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF OHIO
WESTERN DIVISION
Title omitted in printing.

Plaintiffs' Opposition To
Defendant's Second Motion To Dismiss
Attachment B-2

Excerpts from FYE 1980 Cost Report
DEACONESS HOSPITAL

45a

Form Approved
OMB No. 68-R0078

WORKSHEET CHECKLIST FOR HOSPITAL, HOSPITAL-SKILLED NURSING FACILITY COMPLEX AND SKILLED NURSING FACILITY COST REPORT

PROVIDER NO. 54-0038 | PERIOD 1 FROM 1-1-79 TO 12-31-79

	CHECK THE APPROPRIATE COLUMN FOR EACH WORKSHEET	Completed: HCFA Worksheet	Completed: Substitute Worksheet	Not Applicable
	WORKSHEETS	1	2	3
1	Worksheet Checklist	✓		
2	Hospital and Hospital-Skilled Nursing Facility Complex and Skilled Nursing Facility Statistical Data – Part I	✓		
3	Hospital and Hospital-Skilled Nursing Facility Complex and Skilled Nursing Facility Statistical Data – Parts II and III		✓	
4	Hospital and Hospital-Skilled Nursing Facility Complex and Skilled Nursing Facility Statistical Data – Parts IV and V	✓		
5	Worksheet A		✓	
6	Worksheet A-1		✓	
7	Worksheet A-2		✓	
8	Worksheet A-3		✓	
9	Worksheet A-4		✓	
10	Worksheet A-5		✓	
11	Worksheet A-6		✓	
12	Worksheet A-7	✓		
13	Worksheet A-8		✓	
14	Worksheet A-8-1	✓		
15	Worksheet A-8-2	✓		
16	Worksheet B		✓	
17	Worksheet B-1		✓	
18	Worksheet C		✓	
19	Worksheet D		✓	
20	Worksheet D-1 – Part I (All Pages Must Be Completed)		✓	
21	Worksheet D-1 – Part II		✓	
22	Worksheet D-2	✓		
23	Worksheet D-3		✓	
24	Worksheet D-4		✓	
25	Worksheet E – Part I		✓	
26	Worksheet E – Part II		✓	
27	Worksheet E – Part III		✓	
28	Worksheet E-1	✓		
29	Worksheet E-2		✓	
30	Worksheet E-5 – Parts I and II	✓		
31	Worksheet E-5 – Part III	✓		
32	Worksheet G	✓		
33	Worksheet G-1	✓		
34	Worksheet G-2	✓		
35	Worksheet G-3	✓		

SUPPLEMENTAL WORKSHEETS (AVAILABLE UPON REQUEST FROM INTEMEDIARY)

36	HCFA-2562A – Supplemental Worksheet D-4			
37	HCFA-2562A – Supplemental Worksheet D-5			
38	HCFA-2562B – Supplemental Worksheet D-6			
39	HCFA-2562C – Supplemental Worksheet D-7			
40	HCFA-2562D – Supplemental Worksheet E-3			
41	HCFA-2562E – Supplemental Worksheet E-4			
42	HCFA-2562F – Supplemental Worksheet E-4-1			
43	HCFA-2562G – Supplemental Worksheet F – Part I			
44	HCFA-2562G – Supplemental Worksheet F – Part II			
45	HCFA-2562G – Supplemental Worksheet F – Part III			
46	HCFA-2562H – Supplemental Worksheet A-8-3			

If substitute worksheets are a part or all of this cost report (a check in column 2), enter the name and address of the person, company or forms preparation service which originated the substitute worksheets:

NAME : KOSTPAK ERNST & WHINNEY

ADDRESS: 1400 DIGIS TOWER

CINCINNATI, OHIO 45202

Form HCFA-2552 (5-80)
Destroy old issue

This report is required by law (42 USC 1395g, 20 CFR 405.406[b]). Failure to report can result in all interim payments made since the beginning of the cost report period being deemed overpayments (42 USC 1395g).

Form Approved
OMB No. 68-R0078

HOSPITAL, HOSPITAL-SKILLED NURSING FACILITY COMPLEX AND SKILLED NURSING FACILITY STATISTICAL DATA	INTERMEDIARY USE ONLY ☐ AUDITED ☐ DESK REVIEWED	DATE RECEIVED / INTERMEDIARY NO.

PART I – GENERAL

1. Names and Addresses	Provider Numbers	Dates Certified
HOSPITAL THE DEACONESS HOSPITAL	36-0038	7-1-66
SUBPROVIDER I		
SUBPROVIDER II		
SKILLED NURSING FACILITY		
HOME HEALTH AGENCY		
SPECIAL PROVIDER-CONTROLLED FACILITY		

2. Cost Reporting Period — From 1-1-80 TO 12-31-80

3. Type of Control

a. Voluntary Nonprofit
- ☐ Church
- ☑ Other (Specify) CORPORATION

b. Proprietary
- ☐ Individual
- ☐ Partnership
- ☐ Corporation
- ☐ Other (Specify)

c. Government
- ☐ Federal
- ☐ State
- ☐ Other (Specify)
- ☐ City-County
- ☐ Hospital District
- ☐ County
- ☐ City

4. Type of Hospital

a.
- ☑ General-Short Term
- ☐ General-Long Term
- ☐ Tuberculosis
- ☐ Specialty Short-Term
- ☐ Specialty Long-Term
- ☐ Chronic Disease
- ☐ Psychiatric
- ☐ Other (Specify) _____

b. Medicare Certified Kidney Transplant Hospital — ☐ Yes ☑ No

5. Type of Skilled Nursing Facility
- ☐ Entirely Certified Skilled Nursing Facility
- ☐ Partially Certified Skilled Nursing Facility
- ☐ Skilled Nursing Facility Unit of Domiciliary Institution
- ☐ Skilled Nursing Facility Unit of Rehabilitation Center
- ☐ Other (Specify)

6. Health Care Programs — ☑ Title V ☑ Title XVIII ☑ Title XIX

7. a. Are management and/or administrative support services purchased from an outside supplier or organization? OHMS - A&A — ☑ Yes ☐ No

b. If yes, what is the total amount for these services included on Worksheet A, column 7? $ [illegible]

INTENTIONAL MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above statement and that I have examined the accompanying Statement of Reimbursable Cost and the Balance Sheet and Statement of Revenue and Expense prepared by THE DEACONESS HOSPITAL 36-0038 (Provider name(s) and number(s)) for the cost report period beginning 1-1-80 and ending 12-31-80, and that to the best of my knowledge and belief, it is a true, correct, and complete statement prepared from the books and records of the provider(s) in accordance with applicable instructions, except as noted. THE ATTACHED NOTES ARE AN INTEGRAL PART OF THIS REPORT AS PRESENTED.

(Signed) _____
Officer or Administrator of Provider(s)

Title ASSISTANT ADMINISTRATOR - FINANCE

Date

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ERNST [illegible] HOSPITAL SYSTEM
DEACON [illegible] HOSPITAL PROV ID 36-0039 FROM 01/01/80 TO 12/31/80 RUN DATE: 04/16/81
HOSPITAL AND HOSPITAL-SKILLED NURSING FACILITY COMPLEX
STATISTICAL DATA
SUBMITTED IN LIEU OF HCFA-2552, PAGE 3

PART II - HOSPITAL STATISTICS

		SPECIAL CARE UNITS			
					OTHER (SPECIFY)
		GENERAL SERVICE	ICU	CCU	
	INPATIENT - ALL PATIENTS	1	2	3	4	5
1	BEDS (EXCLUDING NEWBORN) AVAILABLE AT BEGINNING OF PERIOD	266	6	6	0	0
2	BEDS (EXCLUDING NEWBORN) AVAILABLE AT END OF PERIOD	266	6	6	0	0
3	TOTAL BED DAYS AVAILABLE (EXCLUDING NEWBORN)	97356	2196	2196	0	0
4	AGED, PEDIATRIC AND MATERNITY INPATIENT DAYS	42861	1080	917	0	0
5	OTHER THAN AGED, PEDIATRIC AND MATERNITY INPATIENT DAYS (EXCLUDING NEWBORN)	38287	587	545	0	0
6	TOTAL INPATIENT DAYS (EXCLUDING NEWBORN)	81148	1667	1462	0	0
7	PERCENT OCCUPANCY	83.35%	75.91%	66.58%	0.00%	0.00%
8	TOTAL NEWBORN INPATIENT DAYS	0	-----	-----	-----	-----
	INPATIENT - HEALTH CARE PROGRAMS	-----	-----	-----	-----	-----
9	TITLE V	-----	-----	-----	-----	-----
	A INPATIENT DAYS (EXCLUDING NEWBORN)	0	0	0	0	0
	B NEWBORN INPATIENT DAYS	0	-----	-----	-----	-----
10	TITLE XVIII	-----	-----	-----	-----	-----
	A AGED, PEDIATRIC AND MATERNITY INPATIENT DAYS (EXCLUDING KIDNEY ACQUISITION DAYS)	39567	1012	842	0	0
	B KIDNEY ACQUISITION DAYS (AGED, PEDIATRIC, AND MATERNITY)	0	0	0	0	0
	C TOTAL AGED, PEDIATRIC, AND MATERNITY INPATIENT DAYS	39567	1012	842	0	0
	D OTHER THAN AGED, PEDIATRIC AND MATERNITY INPATIENT DAYS (EXCLUDING KIDNEY ACQUISITION DAYS)	2295	47	45	0	0
	E KIDNEY ACQUISITION DAYS (OTHER THAN AGED, PEDIATRIC AND MATERNITY)	0	0	0	0	0
	F TOTAL OTHER THAN AGED, PEDIATRIC AND MATERNITY INPATIENT DAYS	2295	47	45	0	0
	G TOTAL INPATIENT DAYS (EXCLUDING KIDNEY ACQUISITION DAYS)	41862	1059	887	0	0
	H TOTAL KIDNEY ACQUISITION DAYS	0	0	0	0	0
	I TOTAL PART A INPATIENT DAYS	41862	1059	887	0	0
	J TOTAL PART B INPATIENT DAYS	0	0	0	0	0
	K PART B INPATIENT DAYS WHEN PART A BENEFITS ARE NOT AVAILABLE	661	0	0	0	0
11	TITLE XIX	-----	-----	-----	-----	-----
	A INPATIENT DAYS (EXCLUDING NEWBORN)	0	0	0	0	0
	B NEWBORN INPATIENT DAYS	0	-----	-----	-----	-----

	OUTPATIENT - HEALTH CARE PROGRAMS	TITLE V	TITLE XVIII	TITLE XIX	ALL OTHER	TOTAL
12	NUMBER OF OCCASIONS OF SERVICE (EXCLUSIVE OF RENAL DIALYSIS TREATMENTS)	0	6576	0	44986	51562

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[illegible] PROVIDER [illegible] PERIOD FROM 01/01/80 TO 12/31/80 RUN DATE: 04/16/81
HOSPITAL AND HOSPITAL-SKILLED NURSING FACILITY COMPLEX
STATISTICAL DATA
SUBMITTED IN LIEU OF HCFA-2552, PAGE 3 (CONTD)

PART III - OTHER HOSPITAL DATA

1 AMOUNT OF ACCELERATED PAYMENTS OUTSTANDING AS OF END OF COST REPORTING PERIOD - TITLE XVIII $	0
2 AVERAGE NUMBER OF EMPLOYEES ON PAYROLL FOR THE PERIOD (FULL-TIME EQUIVALENT) - EXCLUDES NONPAID WORKERS	723
3 AVERAGE NUMBER OF NONPAID WORKERS FOR THE PERIOD (FULL-TIME EQUIVALENT) FOR WHICH REIMBURSEMENT IS CLAIMED	0
4 NUMBER OF RENAL DIALYSIS TREATMENTS (INPATIENT AND OUTPATIENT)	
A TOTAL - ALL HOSPITAL PATIENTS	0
B TITLE V	0
C TITLE XVIII	0
D TITLE XIX	0
5 NUMBER OF ADMISSIONS (EXCLUDING NEWBORN)	10337
A TOTAL - ALL HOSPITAL INPATIENTS	0
B TITLE V	3913
C TITLE XVIII	0
D TITLE XIX	0
6 NUMBER OF DISCHARGES INCLUDING DEATHS (EXCLUDING NEWBORN)	10365
A TOTAL - ALL HOSPITAL INPATIENTS	0
B TITLE V	3910
C TITLE XVIII	0
D TITLE XIX	0
7 AVERAGE LENGTH OF STAY	8.16
A TOTAL	0.00
B TITLE V	11.20
C TITLE XVIII	0.00
D TITLE XIX	

HOSPITAL, HOSPITAL-SKILLED NURSING FACILITY COMPLEX AND SKILLED NURSING FACILITY STATISTICAL DATA	PROVIDER NO. 36-0038	PERIOD: FROM 1-1-80 TO 12-31-80

PART IV - SUBPROVIDER AND SKILLED NURSING FACILITY STATISTICS

	INPATIENT - ALL PATIENTS	SUBPROVIDER I	SUBPROVIDER II	SKILLED NURSING FAC - TY CERTIFIED PORTION	SKILLED NURSING FAC - TY NONCERTIFIED PORTION
		1	2	3	4
1	Beds (excluding newborn) available at beginning of period	N/A	N/A	N/A	N/A
2	Beds (excluding newborn) available at end of period				
3	Total bed days available (excluding newborn)				
4	Aged, pediatric and maternity inpatient days				
5	Other than aged, pediatric and maternity inpatient days (excluding newborn)				
6	Total inpatient days (excluding newborn) (Sum of lines 4 and 5)				
7	Percent occupancy (line 6 ÷ line 3)	%	%	%	%
8	Total newborn inpatient days				
	INPATIENT - HEALTH CARE PROGRAMS				
9	TITLE V				
	a. Inpatient days (excluding newborn)				
	b. Newborn inpatient days				
10	TITLE XVIII				
	a. Aged, pediatric and maternity inpatient days (excluding kidney transplant days)				
	b. Kidney transplant days (aged, pediatric and maternity)				
	c. Total aged, pediatric and maternity inpatient days (Sum of lines 10a and 10b)				
	d. Other than aged, pediatric and maternity inpatient days (excluding kidney transplant days)				
	e. Kidney transplant days (other than aged, pediatric and maternity)				
	f. Total other than aged, pediatric and maternity inpatient days (Sum of lines 10d and 10e)				
	g. Total inpatient days (excluding kidney transplant days) (Sum of lines 10c and 10d)				
	h. Total kidney transplant days (Sum of lines 10b and 10e)				
	i. Total Part A inpatient days (Sum of lines 10g and 10h)				
	j. Total Part B inpatient days (SEE INSTRUCTIONS)				
	k. Part B inpatient days where Part A benefits are not available (SEE INSTRUCTIONS)				
11	TITLE XIX				
	a. Inpatient days (excluding newborn)				
	b. Newborn inpatient days				

PART V - OTHER SUBPROVIDER AND SKILLED NURSING FACILITY DATA

		SUBPROVIDER I	SUBPROVIDER II	SKILLED NURS FACILITY
1	Amount of accelerated payments outstanding as of end of last reporting period - Title XVIII	$ 0	$ 0	$ 0
2	Average number of employees on payroll for the period (full-time equiv.) - exclude unpaid workers			
3	Average number of unpaid workers for the period (full-time equiv.) for which reimbursement is claimed			
4	Number of occasions of service - OUTPATIENTS (exclusive of renal dialysis treatments)			
	a. Total - All OUTPATIENTS			
	b. Title V			
	c. Title XVIII			
	d. Title XIX			
5	Number of renal dialysis treatments			
	a. Total - All PATIENTS			
	b. Title V			
	c. Title XVIII			
	d. Title XIX			
6	Number of admissions (excluding newborn)			
	a. Total - All inpatients			
	b. Title V			
	c. Title XVIII			
	d. Title XIX			
7	Number of discharges including deaths (excluding newborn)			
	a. Total - All inpatients			
	b. Title V			
	c. Title XVIII			
	d. Title XIX			
8	Average length of stay			
	a. Total (Part IV, line 6 ÷ Part V, line 7a)			
	b. Title V (Part IV, line 8a ÷ Part V, line 7b)			
	c. Title XVIII (Part IV, line 10c ÷ Part V, line 7c)			
	d. Title XIX (Part IV, line 11a ÷ Part V, line 7d)			

Form HCFA-2552 (5-80)

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[illegible] SYSTEM
PEACON HOSPITAL PROV NO 36-0039 FROM 01/01/80 TO 12/31/80 RUN DATE: 04/15/81
RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES
SUBMITTED IN LIEU OF HCFA-2552a PAGE 5 WORKSHEET A

E&W HCFA CST LINE CTR NUM-NBR NEW	COST CENTER	SALARIES 1	OTHER 2	TOTAL 3	RECLASSIFICATIONS 4	RECLASSIFIED TRIAL BALANCE 5	ADJUSTMENTS TO EXPENSES 6	NET EXPENSES FOR COST ALLOCATION 7
--- 1	REVENUE SERVICE COST CENTERS	-----	-----	-----	-----	-----	-----	-----
101 2	DEPRECIATION-BUILDING	-----	818212	818212	1225854	2044066	-198362	1845704
102 3	DEPRECIATION-EQUIPMENT	-----	457381	457381	0	457381	0	457381
103 4	EMPLOYEE HEALTH AND WELFARE	0	0	0	230761	230761	0	230761
104 5	OTHER ADMINISTRATIVE	1054969	2739719	3794688	-1669999	2126590	318126	2444716
105 6A	PARKING GARAGE	74506	19249	93755	-29923	63832	-63832	0
106 7A	PLANT & MAINTENANCE	451166	1096193	1547359	0	1547359	-3154	1544205
107 8	LAUNDRY & LINEN	195758	254275	450033	0	450033	0	450033
108 9	HOUSEKEEPING	500252	231877	732129	0	732129	0	732129
109 10	DIETARY	686558	811028	1497586	-492403	1005183	0	1005183
110 11	CAFETERIA	0	0	0	492403	492403	0	492403
111 13	NURSING ADMINISTRATION	301673	78762	380435	0	380435	0	380435
112 14	MEDICAL SUPPLIES	176315	834103	1010418	-794344	216074	-521	215553
113 15	PHARMACY	314841	776973	1091814	0	1091814	-21911	1069903
114 16	MEDICAL RECORDS	195419	105788	301207	-1517	299690	-9223	290467
115 17	SOCIAL SERVICE	101994	23039	125733	-23490	102243	0	102243
116 18	NURSING SCHOOL	377444	140459	517903	0	517903	-96184	421719
117 20A	BLANK	0	0	0	0	0	0	0
118 20B	BLANK	0	0	0	0	0	0	0
119 20C	BLANK	0	0	0	0	0	0	0
--- 21	ANCILLARY SERVICE COST CENTERS	-----	-----	-----	-----	-----	-----	-----
120 22A	SURGERY & RECOVERY	707142	409230	1116372	0	1116372	0	1116372
121 37	E K G	53244	96793	150037	0	150037	-74086	75951
122 43A	E E G	2012	53943	55955	0	55955	-52692	3263
123 25	ANESTHESIA	0	80067	80067	0	80067	0	80067
124 28	RADIOLOGY	381189	1144105	1525294	0	1525294	-479163	1046131
125 29	LABORATORY	529154	868602	1397756	0	1397756	-173381	1224375
126 30	BLOOD	0	71858	71858	0	71858	0	71858
127 31	E E G	12951	26654	39605	0	39605	-15557	24048
128 33	OXYGEN THERAPY	161860	60429	222289	0	222289	0	222289
129 34	PHYSICAL THERAPY	109794	27324	137118	0	137118	0	137118
130 35	COST OF MEDICAL SUPPLIES SOLD	0	0	0	794344	794344	0	794344
131 40	COST OF DRUGS SOLD	0	0	0	0	0	0	0
132 43A	PULMONARY FUNCTION	12750	13933	26283	0	26283	-7820	18463
133 43B	B B G	1829	2795	4624	0	4624	-1904	2720
134 43C	STRESS TEST	3693	10782	14475	0	14475	-9491	4984
135 43D	HOLTER MONITOR	10205	24967	35172	0	35172	-21774	13398
136 43F	BLANK	0	0	0	0	0	0	0
137 43F	BLANK	0	0	0	0	0	0	0
138 43G	BLANK	0	0	0	0	0	0	0
--- 45	INPATIENT ROUTINE SERVICE COST CENTERS	-----	-----	-----	-----	-----	-----	-----
139 46	ROUTINE INPATIENT	3297301	748529	4045830	0	4045830	0	4045830
140 47	I C U	232867	65143	298010	0	298010	0	298010
141 48	C C U	202964	42809	245773	0	245773	0	245773
142 48A	BLANK	0	0	0	0	0	0	0
143 48B	BLANK	0	0	0	0	0	0	0

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FORM [illegible]
HEADER [illegible] FROM 01/01/90 TO 12/31/90 RUN DATE: 04/16/91
RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES
SUBSTITUTE IN LIEU OF HCFA-2552A PAGE 5 (CONTINUED) WORKSHEET A

RAW HCFA CST CTR NUM-BER	COST CENTER	SALARIES 1	OTHER 2	TOTAL 3	RECLASSIFICATIONS 4	RECLASSIFIED TRIAL BALANCE 5	ADJUSTMENTS TO EXPENSES 6	NET EXPENSES FOR COST ALLOCATION 7
--- 54	OUTPATIENT SERVICE COST CENTERS	-----	-----	-----	-----	-----	-----	-----
145 56	EMERGENCY	218572	324512	543084	0	543084	-256114	286970
146 56A	BLANK	0	0	0	0	0	0	0
147 56P	BLANK	0	0	0	0	0	0	0
--- 58	OTHER REIMBURSABLE COST CENTERS	-----	-----	-----	-----	-----	-----	-----
148 66A	HOUSE PHYSICIANS	68224	443384	512608	0	512608	0	512608
149 69A	UTILIZATION REVIEW	0	0	0	25007	25007	-25007	0
150 67	MALPRACTICE	0	0	0	243306	243306	-243306	0
151 65A	BLANK	0	0	0	0	0	0	0
152 65P	BLANK	0	0	0	0	0	0	0
--- 73	SUBTOTAL	10454046	12893717	23347763	0	23347763	-1440356	21907407
--- 74	NONREIMBURSABLE COST CENTERS	-----	-----	-----	-----	-----	-----	-----
153 75	GIFT SHOP	0	0	0	0	0	0	0
154 7HA	RENTED SPACE	0	0	0	0	0	0	0
155 7HH	BLANK	0	0	0	0	0	0	0
156 7HC	BLANK	0	0	0	0	0	0	0
157 7HD	BLANK	0	0	0	0	0	0	0
158 7HE	BLANK	0	0	0	0	0	0	0
159 7HF	BLANK	0	0	0	0	0	0	0
160 7HG	BLANK	0	0	0	0	0	0	0
161 7HH	BLANK	0	0	0	0	0	0	0
162 7HI	BLANK	0	0	0	0	0	0	0
163 7HJ	BLANK	0	0	0	0	0	0	0
164 7HK	BLANK	0	0	0	0	0	0	0
165 7HL	BLANK	0	0	0	0	0	0	0
166 7HM	BLANK	0	0	0	0	0	0	0
167 7HN	BLANK	0	0	0	0	0	0	0
168 7HO	BLANK	0	0	0	0	0	0	0
169 7HP	BLANK	0	0	0	0	0	0	0
170 7HQ	BLANK	0	0	0	0	0	0	0
171 7HW	BLANK	0	0	0	0	0	0	0
172 7HZ	BLANK	0	0	0	0	0	0	0
--- 80	TOTAL	10454046	12893717	23347763	0	23347763	-1440356	21907407

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[illegible] RUN DATE: 04/16/91

ADJUSTMENTS TO EXPENSES

SUBMITTED IN LIEU OF HCFA-2552, PAGE 11

WORKSHEET A-8

	DESCRIPTION	BASIS FOR ADJUST-MENT		AMOUNT	EXPENSE CLASSIFICATION ON WORKSHEET A FROM WHICH THE AMOUNT IS TO BE DEDUCTED OR TO WHICH THE AMOUNT IS TO BE ADDED: COST CENTER	HCFA LINE NO.	ESC COST CTR NO.
		1		2	3	4	
1	INVESTMENT INCOME ON COMMINGLED RESTRICTED AND UNRESTRICTED FUNDS (CHAPTER 2)	B	$	-143343	DEPRECIATION-BUILDING	2	101
2	STAFF, QUANTITY, TIME AND DISCOUNTS ON PURCHASES (CHAPTER 9)	B		-9599	OTHER ADMINISTRATIVE	5	104
3	REBATES AND REFUNDS OF EXPENSES (CHAPTER 61			0			0
4	RENTAL OF PROVIDER SPACE BY SUPPLIERS (CHAPTER 8)			0			0
5	TELEPHONE SERVICE (PAY STATIONS EXCLUDED) (CHAPTER 21)	A		-84869	OTHER ADMINISTRATIVE	5	104
6	TELEVISION AND RADIO SERVICE (CHAPTER 21)	A		-196	PLANT & MAINTENANCE	7A	104
7	PARKING LOT (CHAPTER 21)	H		-68832	PARKING GARAGE	6A	103
8	RECLASSIFICATION APPLICABLE TO PROVIDER-BASED RADIOLOGISTS FOR PROFESSIONAL SERVICES (CHAPTER 21)	A		-479163	RADIOLOGY	28A	124
9	RECLASSIFICATION APPLICABLE TO PROVIDER-BASED PATHOLOGISTS FOR PROFESSIONAL SERVICES (CHAPTER 21)	A		-173381	LABORATORY	29	125
10	RECLASSIFICATION APPLICABLE TO PROVIDER-BASED ANESTHESIOLOGISTS FOR PROFESSIONAL SERVICES (CHAPTER 21)			0			0
11	RECLASSIFICATION APPLICABLE TO PROVIDER-BASED CARDIOLOGISTS FOR PROFESSIONAL SERVICES (CHAPTER 21)	A		-74086	E K G	37	121
12	RECLASSIFICATION APPLICABLE TO PROVIDER-BASED RADIOLOGISTS FOR PROFESSIONAL SERVICES (CHAPTER 21)	A		-15557	E E G	38	127
13	RADIOLOGY - THERAPEUTIC			0			0
14	RADIOISOTOPE			0			0
15	NUCLEAR MEDICINE			0			0
16	PULMONARY FUNCTION	A		-7828	PULMONARY FUNCTION	43A	132
17	HOME OFFICE COSTS (CHAPTER 21)			0			0
18	SALE OF SCRAP, WASTE, ETC. (CHAPTER 23)			0			0
19	NONALLOWABLE COSTS RELATED TO CERTAIN CAPITAL EXPENDITURES (CHAPTER 24)			0			0
20	ADJUSTMENT RESULTING FROM TRANSACTIONS WITH RELATED ORGANIZATIONS (CHAPTER 10)			0			0
21	LIBRARY AND LIBRARY SERVICE			0			0
22	CAFETERIA - EMPLOYEES, GUESTS, ETC.			0			0
23	RENTAL OF LIVING QUARTERS TO EMPLOYEES AND OTHERS			0			0
24	SALE OF MEDICAL AND SURGICAL SUPPLIES TO OTHER THAN PATIENTS	H		-521	MEDICAL SUPPLIES	14	112
25	SALE OF DRUGS TO OTHER THAN PATIENTS	H		-21911	PHARMACY	15	113
26	SALE OF MEDICAL RECORDS AND ABSTRACTS	H		-9223	MEDICAL RECORDS	16	114
27	NURSING SCHOOL (TUITION, FEES, TEXTBOOKS, UNIFORMS, ETC.)	H		-96196	NURSING SCHOOL	18	116
28	[illegible]	H		-2958	PLANT & MAINTENANCE	7A	104
29	INCOME FROM DEPOSITION OF INTEREST, FINANCE OR PENALTY CHARGES (CHAPTER 21)			0			0
30	ADD	A		-52692	E M G	43A	122
31	ADD	A		-1984	P R G	43B	133

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WORKSHEET A-8

	DESCRIPTION	BASIS FOR ADJUST-MENT	AMOUNT	EXPENSE CLASSIFICATION ON WORKSHEET A FROM WHICH THE AMOUNT IS TO BE DEDUCTED OR TO WHICH THE AMOUNT IS TO BE ADDED: COST CENTER	HCFA LINE NO.	HCFA COST CTR NO.
		1	2	3	4	
33	SUBTOTAL	---	$ -1242239			
34	ADJUSTMENTS FOR PHYSICAL THERAPY COSTS IN EXCESS OF LIMITATION (CHAPTER 14)		0			0
35	MALPRACTICE PREMIUMS AND/OR SELF-INS. FUND CONTRIBUTIONS (CHAPTER 21)	A	-243306	MALPRACTICE	67	156
36	ALLOWABLE PAID TITLE XVIII MALPRACTICE LOSSES (CHAPTER 21)		0			0
37	ALLOWABLE RELATED DIRECT EXPENSES TO PAID TITLE XVIII MALPRACTICE LOSSES (CHAPTER 21)		0			0
38	ALLOWABLE PAID TITLE XIX MALPRACTICE LOSSES (CHAPTER 21)		0			0
39	ALLOWABLE RELATED DIRECT EXPENSES TO PAID TITLE XIX MALPRACTICE LOSSES (CHAPTER 21)		0			0
40	ALLOWABLE PAID TITLE V MALPRACTICE LOSSES (CHAPTER 21)		0			0
41	ALLOWABLE RELATED DIRECT EXPENSES TO PAID TITLE V MALPRACTICE LOSSES (CHAPTER 21)		0			0
42	ALLOWABLE PAID MALPRACTICE LOSSES AND RELATED DIRECT EXPENSES APPLICABLE TO THE HOME HEALTH AGENCY		0			0
43	NONALLOWABLE MALPRACTICE PREMIUMS, PAID LOSSES AND RELATED EXPENSES (CHAPTER 21)		0			0
44			0			0
45	PSRO COSTS (FEDERAL OR COMBINED) (P.L. 93-641, PART I, 1975 AMENDMENTS)		0			0
46	PSRO COSTS (NON-FEDERAL ONLY) (P.L. 93-641, PART I, 1975 AMENDMENTS)		0			0
47	EMERGENCY ROOM	A	-256114	EMERGENCY	56	145
48	LOSS ON DISPOSALS	A	1408	DEPRECIATION-BUILDING	2	101
49	BAD DEBTS	A	391361	OTHER ADMINISTRATIVE	5	104
50	CHARITY	A	884	OTHER ADMINISTRATIVE	5	104
51	PSRO COSTS	A	-25007	UTILIZATION REVIEW	69A	149
52	UNEMPLOYMENT TO CASH BASIS	A	5719	OTHER ADMINISTRATIVE	5	104
53	WORKERS COMP TO CASH BASIS	A	1612	OTHER ADMINISTRATIVE	5	104
54	STRESS TEST	A	-9491	STRESS TEST	43C	134
55	HOLTER MONITOR	A	-21774	HOLTER MONITOR	43D	135
56	MORD SER RES INTEREST	B	-71251	DEPRECIATION-BUILDING	2	101
57	AMORTIZATION	A	-32497	DEPRECIATION-BUILDING	2	101
57A	MISCELLANEOUS INCOME	B	-6982	OTHER ADMINISTRATIVE	5	104
58	SUBTOTAL	---	$ -1507677			
59	GRANTS, GIFTS, AND INCOME DESIGNATED BY DONOR FOR SPECIFIC EXPENSES (CHAPTER 6)		0			0
60	UTILIZATION REVIEW - PHYSICIANS' COMPENSATION (CHAPTER 21)		0			0
61	DEPRECIATION - BUILDINGS AND FIXTURES	A	67321	DEPRECIATION-BUILDING	2	101
62	DEPRECIATION - MOVABLE EQUIPMENT		0			0
63			0			0
64	TOTAL	---	$ -1440356			

BASIS FOR ADJUSTMENT
A. COSTS--IF COSTS, INCLUDING APPLICABLE OVERHEAD, CAN BE DETERMINED.
B. AMOUNT RECEIVED--IF COST CANNOT BE DETERMINED.

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF OHIO
WESTERN DIVISION

NO: C-1-83-622

BETHESDA HOSPITAL, ET AL., PLAINTIFFS,

v.

MARGARET M. HECKLER,
SECRETARY OF HEALTH
& HUMAN SERVICES, DEFENDANT.

(Filed Nov. 25, 1985)

ORDER OF REMAND

This matter came on for consideration of plaintiffs' motion for a money judgment in the amount of $2,965,767, plus post-judgment interest, at the statutory rate (doc. 60). Defendant opposes the motion and has filed a motion to remand (doc. 63). Plaintiffs have filed their reply (doc. 64), defendant has filed its supplemental memoranda (docs. 65 and 67), and plaintiffs have filed two notices of new authority (docs. 66 and 68).

Previously, we have entered summary judgments in favor of the plaintiffs (doc. 58) on the question of liability, and we asked the parties to brief the issues of appropriate relief. After examining 42 U.S.C. § 1395(oo), which includes judicial review of the decision of the Provider Reimbursement Review Board and the Secretary and refers to the manner in which judicial review will be accomplished pursuant to Chapter 7 of Title 5 of the United States Code, we conclude that Title 5, U.S.C. § 706 does

not provide for the granting of a judgment as prayed for by plaintiffs. Rather, the reviewing court shall:

1) compel agency action unlawfully withheld or unreasonably delayed; and
2) hold unlawful and set aside agency action, findings, and conclusions found to be–
   (A) arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law.

42 U.S.C. § 706.

Therefore, we believe that the appropriate relief for this case is to remand this case to the Secretary of Health & Human Services for further proceedings consistent with this Court's Opinion, including the granting of judgment to plaintiffs in the amount of $2,965,767, plus post-judgment interest at the statutory rate in accordance with the schedule attached to plaintiffs' motion and incorporated by reference herein. The schedule lists the amounts previously determined by the Provider Reimbursement Review Board to be due to each listed hospital for all cost reporting years under appeal and which lists the pre-judgment interest due through April 30, 1985 in accordance with 42 U.S.C. § 1395(oo)(f)(2).

We specifically decline to remand this case to the Secretary for retroactive rule making or to stay this case pending completion of the rule making initiated by the Secretary on June 17, 1985. It is also unnecessary to stay this case, as the Supreme Court of the United States has denied the petitions for certiorari of the Secretary in *Heckler v. Abington Memorial Hospital,* No. 85-52 and *Heckler v. Humana of Aurora, Inc., dba Aurora Community Hospitals,* No. 85-53 (*see* 54 U.S.L.W. 3227, October 7, 1985).

SO ORDERED.

/s/ S. ARTHUR SPIEGEL

S. Arthur Spiegel
United States District Judge

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF OHIO
WESTERN DIVISION

No: C-1-83-622
(Spiegel, J.)

BETHESDA HOSPITAL, ET AL., PLAINTIFFS,

v.

OTIS R. BOWEN, M.D.,
SECRETARY OF HEALTH
and HUMAN SERVICES, DEFENDANT.

(Filed Feb. 20, 1986)

AMENDMENT TO ORDER ENTERED NOVEMBER 25, 1985

Having considered defendant's motion to amend judgment, plaintiffs' response, and the full record herein, it is this 19th day of February, 1986, hereby

ORDERED that defendant's motion to amend judgment be, and it hereby is, granted in part, and

IT IS FURTHER ORDERED that the next to last full paragraph of the court's Order dated November 15, 1985, be amended as follows:

> Therefore, we believe that the appropriate relief for this case is to remand this case to the Secretary of Health and Human Services and that defendant shall pay plaintiffs, for all cost reporting periods under appeal, its costs of malpractice insurance under the prior valid regulation, 42 CFR § 405.452(a)(1)(i)(1983) without reference to the invalidated exception in 42 CFR § 405.452(a)(1)(ii), plus interested

> computed to the date of payment, in accordance with 42 U.S.C. § 1395oo(f)(2). Such calculation and payment is to be accomplished within 60 days.

IT IS FURTHER ORDERED that the following paragraph be added to the end of the court's order dated November 25, 1985:

> Having determined that this court is without jurisdiction to rule on the merits of the claims of Bethesda Hospital and Deaconess Hospital until those claims are reviewed on their merits by the Provider Reimbursement Review Board, or until the Board decides that it is without jurisdiction to review those claims on their merits because they involve a challenge to a Medicare regulation, the claims of Bethesda Hospital and Deaconess Hospital are hereby remanded to the Board for action within thirty days of this order: either an order granting expedited judicial review or a decision upon its review of the merits of the remanded claims.

/s/ SPIEGEL, J.
United States District Judge

UNITED STATES COURT OF APPEALS
FOR THE SIXTH CIRCUIT

Title omitted in printing.

ERNST & WHINNEY KOSTPAK SYSTEM
BETHESDA HOSPITAL PROV # 36-0193 FYE 12/31/80
APPORTIONMENT OF MALPRACTICE INSURANCE COSTS
SUBMITTED IN LIEU OF HCFA-2552, PAGE 27
HOSPITAL

RUN DATE: 04/20/81

WORKSHEET D-8

PART I - PAID MALPRACTICE LOSSES

		TITLE V 1	TITLE XVIII 2	TITLE XIX 3	OTHER 4	TOTAL 5
		0	7261	0	2498	9759
1 CURRENT PERIOD LOSSES						
2 PRIOR PERIOD LOSSES:		0	0	0	0	0
COST REPORTING PERIOD ENDED:	1979	0	0	0	0	0
3	1978	0	0	0	158	158
4	1977	0	0	0	734	734
5	1976	0	7261	0	3390	10651
6 TOTAL						

PART II - APPORTIONMENT TO HEALTH CARE PROGRAMS

7 IF THERE ARE NO ENTRIES ON LINES 1 THROUGH 6, ENTER THE NATIONAL RATIO FOR:

A. TITLE V 0.000000 B. TITLE XVIII 0.000000 C. TITLE XIX 0.000000

IF LINE 7 IS COMPLETED, DO NOT COMPLETE LINES 8, 9 AND 10.

8 RATIO OF TITLE V MALPRACTICE LOSSES TO TOTAL	0.00000000
9 RATIO OF TITLE XVIII MALPRACTICE LOSSES TO TOTAL	0.68172003
10 RATIO OF TITLE XIX MALPRACTICE LOSSES TO TOTAL	0.00000000
11 CURRENT PERIOD MALPRACTICE INSURANCE PREMIUMS OR FUND CONTRIBUTIONS	377217
12 HOME HEALTH AGENCY MALPRACTICE INSURANCE PREMIUMS AND/OR FUND CONTRIBUTIONS	
FROM WKST C, COL 10, HCFA LINE 34A $ 0 / FROM WKST B, COL 21, HCFA LINE 74 $ 18101206 = 0.00000000 X LINE 11	- 0
13 NET MALPRACTICE INSURANCE PREMIUMS AND/OR CONTRIBUTIONS	377217
14 TOTAL TITLE V MALPRACTICE INSURANCE COSTS	0
15 TOTAL TITLE XVIII MALPRACTICE INSURANCE COSTS	257156
16 TOTAL TITLE XIX MALPRACTICE INSURANCE COSTS	0

ERNST & WHINNEY KOSTPAK SYSTEM
BETHESDA HOSPITAL PROV # 36-0193 FYE 12/31/80 RUN DATE: 04/20/81
APPORTIONMENT OF MALPRACTICE INSURANCE COSTS
SUBMITTED IN LIEU OF HCFA-2552- PAGE 27 (CONT'D) WORKSHEET D-3
HOSPITAL

DESCRIPTION	HEALTH CARE PROGRAM CHARGES 1	RATIO 2	COST 3
17 TITLE V			
A HOSPITAL	0	0.00000000	0
B SUBPROVIDER I	0	0.00000000	0
C SUBPROVIDER II	0	0.00000000	0
D TOTAL TITLE V CHARGES	0	0.00000000	0
18 TITLE XVIII			
A HOSPITAL - PART A	6709153	0.95661632	246000
B HOSPITAL - PART B	304268	0.04338368	11156
C SUBPROVIDER I - PART A	0	0.00000000	0
D SUBPROVIDER I - PART B	0	0.00000000	0
E SUBPROVIDER II - PART A	0	0.00000000	0
F SUBPROVIDER II - PART B	0	0.00000000	0
G SKILLED NURSING FACILITY - PART A	0	0.00000000	0
H SKILLED NURSING FACILITY - PART B	0	0.00000000	0
I TOTAL TITLE XVIII CHARGES	7013421	1.00000000	257156
19 TITLE XIX			
A HOSPITAL	0	0.00000000	0
B SUBPROVIDER I	0	0.00000000	0
C SUBPROVIDER II	0	0.00000000	0
D TOTAL TITLE XIX CHARGES	0	0.00000000	0

PART III - DIRECTLY ASSIGNED MALPRACTICE COSTS--TITLE V AND TITLE XIX

	TITLE V 1	TITLE XIX 2
20 HOSPITAL	0	0
21 SUBPROVIDER I	0	0
22 SUBPROVIDER II	0	0

PART IV - DIRECTLY ASSIGNED MALPRACTICE COSTS--TITLE XVIII

	PART A 1	PART B 2
23 HOSPITAL	0	0
24 SUBPROVIDER I	0	0
25 SUBPROVIDER II	0	0
26 SKILLED NURSING FACILITY	0	0

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Title omitted in printing.

[illegible] MEDICARE POSTPAR SYSTEM
[illegible] HOSPITAL PROV NO 36-0039 FROM 01/01/80 TO 12/31/80 RUN DATE: 04/16/81
[illegible] OF MALPRACTICE INSURANCE COSTS
SUBMITTED IN LIEU OF HCFA-2552, PAGE 27 WORKSHEET D-8
HOSPITAL

PART I - PAID MALPRACTICE LOSSES

		TITLE V 1	TITLE XVIII 2	TITLE XIX 3	OTHER 4	TOTAL 5
1	CURRENT PERIOD LOSSES	0	0	0	0	0
2	PRIOR PERIOD LOSSES:					
	COST REPORTING PERIOD ENDED: 1979	0	0	0	3500	3500
3	1978	0	12900	0	29965	41965
4	19	0	0	0	0	0
5	19	0	0	0	0	0
6	TOTAL	0	12900	0	33465	45465

PART II - APPORTIONMENT TO HEALTH CARE PROGRAMS

IF YOU ARE NO ENTRIES ON LINES 1 THROUGH 6, ENTER THE NATIONAL RATIO FOR:

A. TITLE V 0.000000 B. TITLE XVIII 0.000000 C. TITLE XIX 0.000000

IF LINE 7 IS COMPLETED, DO NOT COMPLETE LINES 8, 9 AND 10.

8	RATIO OF TITLE V MALPRACTICE LOSSES TO TOTAL	0.00000000
9	RATIO OF TITLE XVIII MALPRACTICE LOSSES TO TOTAL	0.24393729
10	RATIO OF TITLE XIX MALPRACTICE LOSSES TO TOTAL	0.00000000
11	CURRENT PERIOD MALPRACTICE INSURANCE PREMIUMS OR FUND CONTRIBUTIONS	243306
12	OTHER HEALTH AGENCY MALPRACTICE INSURANCE PREMIUMS AND/OR FUND CONTRIBUTIONS	
	FROM WKST C, COL 10, HCFA LINE 348 $ 0 0.00000000 * LINE 11 =	0
	FROM WKST B, COL 21, HCFA LINE 74 $ 21877603	
13	NET MALPRACTICE INSURANCE PREMIUMS AND/OR CONTRIBUTIONS	243306
14	TOTAL TITLE V MALPRACTICE INSURANCE COSTS	0
15	TOTAL TITLE XVIII MALPRACTICE INSURANCE COSTS	64219
16	TOTAL TITLE XIX MALPRACTICE INSURANCE COSTS	0

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FROST & [illegible]
OPACOMP [illegible] HOSPITAL PMRW #1 34-0039 FOR: 01/01/80 TO 12/31/80 RUN DATE: 04/16/81
APPORTIONMENT OF MALPRACTICE INSURANCE COSTS
SUBMITTED IN LIEU OF HCFA-2552a PAGE 27 (COMPUTED) WORKSHEET D-8
HOSPITAL

DESCRIPTION	HEALTH CARE PROGRAM CHARGES 1	RATIO 2	COST 3
17 TITLE V			
A HOSPITAL	0	0.00000000	0
B SUBPROVIDER I	0	0.00000000	0
C SUBPROVIDER II	0	0.00000000	0
D TOTAL TITLE V CHARGES	0	0.00000000	0
18 TITLE XVIII			
A HOSPITAL - PART A	10971432	0.97163747	62397
B HOSPITAL - PART B	320261	0.02836253	1821
C SUBPROVIDER I - PART A	0	0.00000000	0
D SUBPROVIDER I - PART B	0	0.00000000	0
E SUBPROVIDER II - PART A	0	0.00000000	0
F SUBPROVIDER II - PART B	0	0.00000000	0
G SKILLED NURSING FACILITY - PART A	0	0.00000000	0
H SKILLED NURSING FACILITY - PART B	0	0.00000000	0
I TOTAL TITLE XVIII CHARGES	11291693	1.00000000	64218
19 TITLE XIX			
A HOSPITAL	0	0.00000000	0
B SUBPROVIDER I	0	0.00000000	0
C SUBPROVIDER II	0	0.00000000	0
D TOTAL TITLE XIX CHARGES	0	0.00000000	0

PART III - DIRECTLY ASSIGNED MALPRACTICE COSTS--TITLE V AND TITLE XIX	TITLE V 1	TITLE XIX 2
20 HOSPITAL	0	0
21 SUBPROVIDER I	0	0
22 SUBPROVIDER II	0	0

PART IV - DIRECTLY ASSIGNED MALPRACTICE COSTS--TITLE XVIII	PART A 1	PART B 2
23 HOSPITAL	0	0
24 SUBPROVIDER I	0	0
25 SUBPROVIDER II	0	0
26 SKILLED NURSING FACILITY	0	0

UNITED STATES COURT OF APPEALS
FOR THE SIXTH CIRCUIT

No. 86-3090

BETHESDA HOSPITAL, ET AL., PLAINTIFFS-APPELLEES,

v.

SECRETARY OF HEALTH AND HUMAN SERVICES,
DEFENDANT-APPELLANT.

(Filed Feb. 2, 1987)

Before: KEITH and GUY, Circuit Judges; and EDGAR, District Judge.

JUDGMENT

ON APPEAL from the United States District Court for the Southern District of Ohio.

THIS CAUSE came on to be heard on the record from the said district court and was argued by counsel.

ON CONSIDERATION WHEREOF, It is now here ordered and adjudged by this court that the judgment of the said district court in this case be and the same is hereby affirmed in part and reversed in part, and the case is remanded in accordance with this opinion.

Each party is to bear its own costs on appeal.

ENTERED BY ORDER OF THE COURT
John P. Hehman, Clerk

/s/ JOHN P. HEHMAN
Clerk

A True Copy.
Attest:

/s/ GARY MCCARTHY
Deputy Clerk

Title omitted in printing.
Exhibit B to Petition for Rehearing En Banc

(EXCERPT FROM TRANSCRIPT OF PRRB HEARING)

PEACHFORD HOSPITAL (ATLANTA, GEORGIA)

v.

MUTUAL OF OMAHA INSURANCE COMPANY.

PRRB HEARING DEC. No. 84-D122, MAY 15, 1984
(Cost Reporting Period ending Dec. 31, 1981).

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* * *

MS. KRAUS: The Board has some questions for you. Thank you. Mr. Dudgeon?

EXAMINATION BY MR. DUDGEON:

Q The only thing I'd like to clear up is as to the nature of the dispute. The issue is stated as whether scholastic training costs are allowable costs under the Medicare program. Yet, I gather from reading, that somewhere here that the adjustment made by the Intermediary was only to allocate indirect costs to educational costs that the Provider had already itself disallowed.

What is really in dispute here? What was the adjustment?

A The adjustment made by the Intermediary was the indirect cost. You are correct in that Provider did, when filing the cost report, remove the direct costs. Those direct costs however include not only what we will show later is the direct education portion which is integrated with the therapy portion and what we're trying to say to you and to the Board is that in fact that is an error, an error that the Provider made and then it was compounded again by the Intermediary allocating indirect costs.

Q Did you request that the Intermediary re-open and ask that these costs be allowed, the $102,000 direct cost?

A I'm not sure, to be honest with you, sir. I know we have been in discussion with them concerning this issue.

MR. DUDGEON: We may or may not have a jurisdictional problem here. Ms. Kraus will worry about that during the break and check with our legal officer on it, I gather. I don't have any more questions of this witness.

* * *

WITNESS: Madam Chairman, if I might, I've been given a letter that we wrote to Mutual of Omaha, May 27, 1982 in which we asked that the reconsider the adjustment disallowing school costs. And that was in total, not only our original offset but also the overhead cost that was allocated.

MS. KRAUS: Mr. Hamaker, before we proceed any further and before I seek legal advice, can you tell me exactly what you think is in dispute, what the adjustment was so we can have the jurisdictional matter squared away. I'm a little bit concerned that we do have a problem here in terms of what's in dispute.

MR. HAMAKER: Yes, I think I can. The Provider has removed, did remove, approximately $103,000 of direct costs for this scholastic training expense. The Intermediary then set this, actually restated this by setting it up as a non-reimbursable cost center so that it would receive a share of overhead costs. And I believe that the share of overhead costs amounted to approximately $55,000.

MS. KRAUS: They removed the $103,000 entirely from the cost report? It was not claimed? I don't quite understand.

MR. HAMAKER: The Provider removed that on their filed cost report. So they considered that as not an allowable cost.

MS. KRAUS: That's all the questions I have. I do have a few question of the witness.

EXAMINATION BY MS. KRAUS:

Q You said that this is not just an educational program.

A Yes, ma'am.

Q Now I don't know what you mean by that.

A I think that we will show from the witnesses here that it is an integral part of the treatment process at Peachford Hospital. That is to say that we're not just in there teaching them math, science, etc. But by the structure of the classroom and by the interplay of the teachers with students we will clearly demonstrate this today.

Q You said that the teachers were also therapists.

A That's what I was trying to say earlier.

Q You don't know.

A I don't know.

Q Was this denial of payment a written denial?

A I'm not sure.

Q You don't know.

A I don't think so. I believe it was more oral. We would go to the board and say will you pay and they'll say no we don't pay for institutionalized patients.

Q Thank you.

MS. KRAUS: Thank you very much. Before we proceed, because of this jurisdictional matter, I would like to get clarified, I would like to take a ten minute break.

(BRIEF RECESS)

MS. KRAUS: Ladies and gentlemen, I just would like the record to be clear so there is no question regarding jurisdiction, as I understand it the Provider removed the $103,000 on their filed cost report, basically self disallowing those costs. The Intermediary reinstated those costs as a non-reimbursable cost center in order to pick up its share of indirect.

In view of the fact that the cost report is before this Board, the dispute regarding both directs and indirects will

be heard and the amount in controversy will be the $103,000 plus the $55,000 of indirect. And the basis for the Board accepting that amount as the amount in controversy is provided for under 405.1869 which states that when a cost report is before the Board the Board may exercise jurisdiction over any matter.

This is an unusual case and therefore that is the ruling of this Board.

* * *